PUBLIC HEALTH NURSING

Volume 27 January, 1935 Number 1

PUBLIC HEALTH NURSING

Official Organ of The National Organization for Public Health Nursing, Inc.

VOLUME 27 JANUARY, 1935 Number 1

A HAPPY NEW YEAR TO YOU!

Looking back over the dolorous period from which our country is now emerging, we see that nursing has been tried "as silver is tried" and much dross has been burned away. As it emerges from the crucible of the depression, what do we find? Not the gray ashes of exhaustion but a fine and durable metal, the result of the fusion of many elements, and the vivid glow of a new hope.

Our three national organizations have faced grave problems of organization, of finance, and threats to standards of nursing education and so to nursing service. Each in new ways has shared not only its anxieties but its best assets, its courage and its thinking. Fused by the fires of anxiety for nurses and those whom nurses serve, in whatever capacity, objectives have been clarified, purposes strengthened and activities have become clear cut and purposeful.

Each association still has its own task to do but each is stronger because it shares with the others and the results in organized plans and efforts for the profession have been stimulated and strengthened by the work of the joint boards, by joint committees, by editorial conferences, by joint executive staff meetings, and by closer working relationships at National Headquarters. The Bulletin sponsored by the three associations is one of the tangible evidences of a common purpose which points to the New Day in nursing.

Believing these things, we, your chosen representatives, start the New Year with a joint greeting to the nurses throughout our land. May the year bring you professional success, personal satisfaction, and a growing sense of the importance of your own contribution to the welfare of our people and, through your allegiance to the organizations, to your profession.

Strong in our faith in you and in the combined usefulness of our organizations, we wish you

A HAPPY NEW YEAR.

Susan C. Francis
President, American Nurses' Association

Effie J. Taylor
President, National League of Nursing Education

Amelia Grant
President, National Organization for Public Health Nursing

"FOR THE GOOD OF THE SERVICE"

There is a phrase which has been connected with Army and Navy affairs, in history and fiction, both at home and abroad; it expresses an ideal which has inspired many acts of valor, devotion and sacrifice; it is a phrase which might well serve as a motto for all public health nursing associations; it is: "For the Good of the Service."

Members of boards and managing committees of public health nursing associations, being guardians of the public's money, are pledged to apply the principles of public health nursing to the needs of their particular communities, so that each may have the best possible service. Certainly no expenditure based on sentimentality has any place in the programs of these associations, but any economy which impedes the service is equally unwarranted.

The National Organization for Public Health Nursing has prescribed certain minimum qualifications for nurses serving on the staffs of public health nursing associations, but supposing a nurse to have such qualifications, if she is satisfied to remain limited by them, how long will she give satisfactory service? To remain really alive there must be growth both of knowledge and personality. The lesson the Red Queen taught Alice, that you must keep running to stay where you are, is sound basic philosophy. No service given by either an individual or an association can remain static, for if there is no growth there is bound to be deterioration. It cannot be good economy to send out a nurse whose salary forces her to remain in a rut without opportunity for growth. She cannot promote the "Good of the Service."

We would be shocked if an association were to send a nurse suffering from tonsillitis to give postpartum care in a home; we would probably also be disturbed to have a physically frail nurse sent to give bedside care to a hundred and eighty pound paralytic; but do all of us board members realize how much more than physical health is needed for a public health nursing visit? And if we realize it, do we make it possible for our staff to keep up with the scientific knowledge which is the basis of her work, to get the social training that makes it possible for her to use intelligently all the community resources, to develop her ability to explain and teach the principles of health, to have recreation so that she may have a fresh and sympathetic approach to the problems in the homes to which she goes?

This question of salaries should be determined on the basis of a definite policy. The unemployment situation may make it possible to get nurses for very little, but, living on an inadequate salary, no nurse will be able to give that type of service which the community has a right to expect. The saving resulting from this economy is at the expense of the community; in the end it means exploiting the public who are the associations' clients and contributors. No board member should feel ashamed to pay what he has determined is a proper salary simply because industry is paying less or because perhaps many contributors have had their incomes reduced by half or more. They are not being actuated by sentiment or even generosity but by purely business motives, they have promised the public a certain type of service and therefore must make it possible for the nurse to give it.

This is not the occasion for a discussion of what constitutes a living wage in general; but for a woman who is to do real public health nursing a living wage must allow for more than food, shelter, and clothing. She must be able to study, read, attend lectures, take courses, keep up her affiliations with her professional organizations, have recreation and social intercourse so that she may remain a well rounded human being and return to her professional problems each day with a renewed zest; she must be able to save so that she may be independent in her old age, otherwise her judgment in her work is bound to be clouded by her personal problems.

The actual amount of such a "living-

wage" must be determined for each community as conditions vary enormously in different parts of the country. It would be a good plan if each association worked out a budget for a staff nurse so that the board might realize exactly what it means to live on the salaries they offer. Too often salaries are determined by people who have no conception of the demands or routine of a business job, whose scale of living is so far above that of a staff nurse that they cannot imagine the limitations imposed by a small salary. Many board members' and contributors' incomes have been halved or even quartered, but though this reduction may entail many sacrifices, it is rarely in any way commensurate with a ten or twenty-five per cent cut in a $1,400 salary, for example, which may very well mean that a nurse will be too tired to attend a free lecture after a day's work since she cannot afford the carfare to get there.

To argue that nurses live at home and therefore do not need provision for lodging and only a little for food, limits the association to employing only nurses whose circumstances fit these conditions, and it further means that all employment must be done on a case work basis, determining whether the nurse who lives at home is the sole or partial support of her family, and so involving the association in all manner of complications.

If we admit the necessity for paying a living wage, using "living" in the broadest meaning of the word, we may feel that the retrenchment which faces our association might be made by cutting the salaries of the supervisors or higher paid members of the staff, but again the objection is—it would not be for the good of the service. It is not just because their longer years of training, their greater experience, their heavier responsibilities entitle them to higher salaries, but because these very responsibilities make greater demands upon them, demands which they can meet only by having greater opportunities which the higher salaries make possible. They must keep in constant touch with what is going on in the world and in their communities in all the fields allied to their work, they must be continually preparing themselves for their work as instructors of the staff, and they must be able to meet dozens of varying problems daily with a clear judgment and a free mind. To have free minds their salaries must be large enough to show that the board appreciates the importance and dignity of their positions, and to relieve them of the anxiety for the future which, as older women with the time of their retirement warranting even more consideration, they are bound to feel.

How can an association retire a nurse if it has not made it possible for her to save, and how can it justify keeping her on when her physical strength or mental resiliency are no longer equal to the demands of public health nursing?

Most associations have cut the salaries of their staff one or more times since the depression. In 1930 we felt we were facing an emergency; living expenses were going down, and most nurses had reserves both of strength and money. Now prices are going up, they have lived for five years on an emergency level, financial reserves have been called upon and as there has been no cut in hours of work, in fact often it has meant an increase both in hours and strain, presumably reserves of strength are also gone. Certainly, the time is ripe for a restoration of salary cuts wherever possible and a resumption of the salary schedule.

It cannot be maintained that a further cut in salaries or even a continuance at the present level, if that does not provide an adequate living under conditions today, is for the "good of the service," and it is the duty of every board to scrutinize carefully the salary scale of its staff and to determine whether it is fulfilling its obligations to the community by making it possible for the nurses to give the kind of service to which the public is entitled.

ANNE G. DELLENBAUGH,
Board Member, Community Health Association, Boston, Mass.

HEALTH INSURANCE

Among the many measures being discussed to ensure the economic security of the people of the United States, is one about which we are hearing more and more—health insurance. To most of us and to most people at present, the term is exceedingly vague, meaning anything from a type of insurance that we may as individuals take out with a private insurance company, to something grandiose and Utopian offered by our Government to every one, which at one stroke will solve all our problems of costs of medical and nursing care and make preventive health work a fact in every rural hamlet! In between these extremes are a dozen different conceptions of the term, with one idea fairly common to all—that health insurance should be secured by compulsory contributions from earnings, or by voluntary contributions to a common fund which would ultimately be sufficient to care for losses in earnings due to illness, expenses of illness and—hopefully—a sufficient capital to provide regular supervision of the people's health and all the preventive measures that go to make up an ideal community health program. Theoretically, at least, the plan should become self-supporting—whether under Government control or not.

With all these hazy notions of health insurance at large, we believe public health nurses and board members would be wise to inform themselves as completely as possible on the subject and to read, with an open mind and their own particular background of knowledge and experience, as much of the current opinion and plans as time allows. When, as, and if health insurance ever comes to this country, it will probably affect and be affected by public health nursing. Therefore it behooves us to be intelligent on the subject from the beginning of discussion. To this end we are printing on page 46 a brief reading list on this subject presenting various viewpoints, and we are quoting—with permission—from a pamphlet issued by the Y.M.C.A.* on "The Economic Security of the People" which gives in as brief a form as anything we have seen, an unbiased statement of the present situation in the United States. We also call your attention to the December *Survey Graphic*, a special number devoted to "Buying Health." We are hoping to publish this year some descriptive articles of insurance schemes in other countries, again for information on this general subject to enable our readers to discuss the pros and cons of health insurance and come to their own conclusions. We also urge careful reading of the daily newspapers, since events have acquired a habit of happening so fast that the current literature cannot always keep pace. We quote from the leaflet aforementioned:

THE SITUATION IN THE UNITED STATES

"Except as regards industrial illness, health insurance in this country is conducted by private organizations subject to a minimum of governmental control. These private plans are of many varieties and degrees of importance, and it is not easy to secure comprehensive statistics regarding them. They concern themselves for the most part with replacing earnings due to sickness, rather than with medical care or prevention. These latter, however, have not been neglected and a number of experiments directed toward meeting the costs of medical care, especially in regard to hospitalization, have been initiated in recent years.

Fraternal societies, mutual benefit associations, trade unions, and insurance companies through group health insurance, have all attempted in some degree to solve the problem of indemnifying wage earners against working incapacity, and some of them make provision for medical care to a limited extent. Each of these different types of organizations has its special advantages to offer to the American worker.

The worker may affiliate with the

*General Board, Y.M.C.A., 347 Madison Avenue, New York, N. Y. 25c.

local branch, or lodge, of a fraternal society, made up of a group of individuals in the locality with some common bond or social interest. Members of these societies pay regular dues and occasional assessments which go to defray the cost of social and other activities of the lodge, and of such benefits as are granted in case of illness or death. Although most lodges pay death benefits, less than half make any grants for sickness and, in general, these are not provided under contract. Sickness benefits are usually cash payments and are frequently distributed on the basis of need. Some societies, however, maintain hospitals or sanatoria for the treatment of members and others grant free nursing service to members and their families.

Some of the national and international unions in this country operate sick-benefit schemes. The union dues usually include an amount to cover the cost of this "welfare" protection. As a rule, the benefits take the form of cash payments, although a few unions supply treatment for tuberculous members. The member may receive payment either for general illness or for special occupational disablements.

Mutual benefit societies are associations of workers in industrial or commercial establishments. Originally these societies were formed upon the initiative of the workers, but more recently management has come to take a large interest in sponsoring them. A member pays regular dues to his society—usually through payroll deductions—and any assessment which may be necessary to enable the society to meet its obligations. In some cases assessments entirely take the place of regular dues." . . . "Some of the societies provide their own medical facilities, others employ a visiting doctor at a per capita fee and some grant hospital and nursing services. Preventive measures adopted by various societies sometimes include an annual physical examination and health education. While in most cases the employee is free to join a society, or not, as he pleases, the practice is spreading for the employer, often at the request of the workers themselves, to make membership a condition of employment.

About 1911 the practice was adopted in this country of insuring groups of workers as such rather than as separate individuals. In this case there is a definite guarantee of benefits in the form of an insurance policy issued to the employer and covering all or part of his employees. The premium is paid either by the employer (non-contributory) or by the employer and employees jointly (contributory or coöperative)."

"Group accident and health insurance is generally fixed on a salary basis with benefits limited to two-thirds of the average earnings in each class and ranging as a rule from $5 to $40 weekly. They usually begin on the eighth day of incapacity and continue for thirteen or twenty-six weeks for any disability. All employees, except those over seventy, who are actively at work, may be insured. There are no restrictions regarding previous disability or contributory negligence."

"Plans to furnish medical care may be distinguished according as they are found mainly in remote districts, and are closely tied up with the State Compensation Laws (Industrial Plans), or occur in urban areas where medical facilities are readily obtainable, and provide benefits for non-occupational sickness only. Though the latter cover a relatively small number of persons, they are highly significant as experiments in voluntary sickness insurance. They include private group clinics, community health associations, community hospitals, and medical benefit corporations."

"The private group clinic is a form of organization under which several medical practitioners enter into a coöperative agreement to treat patients, each of whom becomes the responsibility of the entire group of doctors. Although specialties, such as obstetrics and dentistry, are usually excluded, such a group frequently aims at becoming a self-contained medical unit able to care for all ordinary ailments within its own organ-

ization. Group clinics serve their clients either on the usual fee basis, or on a fixed periodic payment basis known as contract practice. The aim of contract practice is to furnish practitioners with a steadier income and to prevent those persons who contract for service from having to meet unexpected, heavy, and perhaps catastrophic charges. The number of private clinics engaged in contract practice has been estimated at 150, most of them operating in the Middle West. Some are very inclusive as regards both the terms of membership and the type of service rendered. Others impose definite restrictions in both these respects. In general, most of the contracts relate to employee groups, so that selection is on a group rather than on an individual basis. Payments may come from employer, employee, or both. Employers sometimes "self-insure" their liability under the Workmen's Compensation Law by contracting with a private group clinic.

A community health association is composed of a group of individuals in a certain locality who voluntarily, and with no thought of financial profit, associate together and arrange with local hospitals and practitioners to provide service for members. The association collects regular dues from its members and assumes all financial risks, none of which fall upon the hospitals or practitioners employed.

A number of community hospitals have adopted the fixed periodic method of payment as a means whereby they can count on receiving at least a certain annual sum from "insured members," and also as a means of reducing their dependence upon voluntary contributions to meet the annual deficits under which they normally operate. Dues from members can be increased in times of rising expenditure. Plans of this type usually provide service on an individual rather than a group basis, and do not operate for profit.

A Student Program Motivates Staff Education

By MARGARET REID

Educational Director, Visiting Nurse Association, Hartford, Conn.

ARTHUR GATES, an eminent educator, defines a motive as any factor which initiates, directs, and sustains activity. Arousing and maintaining the active interest of nurses in self-evaluation was one of the outcomes of a project the main purpose of which was to bring about a finer correlation between classroom teaching and the field practice of undergraduate students affiliating with the Hartford Visiting Nurse Association.

For some time the whole staff—supervisors and field nurses—had been aware of a lack of correlation between theory and practice. A student would say to a supervisor when defending a procedure, "That is what Miss —— demonstrated in class"; or, when discussing health supervision and teaching with the classroom teacher, "The staff nurses do it that way, not as you describe it." A frank appraisal of the situation revealed among others, two pertinent facts. First, a student unconsciously accepts the staff nurse as her real teacher, for she observes the staff nurse in real situations. Second, the staff nurses regarded the student as an outsider who had to be given something to do; who in the main added to her work; and who would probably "mess up her district" if she didn't look out. Looking for a solution to this problem, the supervisory group decided that it was not only natural and right that the staff nurse should be considered by the student as one of her teachers, but that she should be consciously recognized as such. It was recommended, then, that the teaching abilities of the staff nurse be developed and utilized and the following plan was

initiated, known as the "teacher-nurse project," to help staff nurses become good teachers of students.

PREVIOUS METHOD AND THE NEW

In order to appreciate the teacher-nurse program, one should know how student instruction and field supervision had been conducted previously. First, every new procedure or type of visit was demonstrated and discussed in the classroom. Second, the student observed this procedure in the field with a staff nurse and then was permitted to carry it out by herself. Following this a supervisor made periodic field visits with the student and discussed them with her. In other words, all supervision, both in the field and in the office with the exception of the first field observation, was given by the supervisor or her assistant and the educational director. The teacher-nurse project, on the other hand, proposed to have the staff nurse share more extensively the supervisory responsibility for the student. Her duties were outlined as follows:

1. Demonstrate each new type of service in a home (following a class demonstration).
2. Observe the student return the demonstration in this same home. The return demonstration of purely instructional visits obviously had to be held in a different home.
3. Help the student evaluate this return demonstration.
4. Write an appraisal of the return demonstration.
5. Help the student plan her daily work—not just the order of visits but the nursing and teaching content of the visit (so far as the latter can be planned, of course) in relation to the full, long-time health supervisory plan for the family.
6. Discuss progress of student with the supervisor.

In order to assist the teacher-nurse with her newly acquired supervisory responsibilities, the following series of four conferences with the educational director were instituted:

Conference I.

1. Aims of student affiliation: for the student; for the Hartford V.N.A.; and for the field nurse.
2. Desirable qualifications of a teacher-nurse.
3. The course of study—content and special emphases, or themes, permeating the course, such as,
   a. The main functions of a public health nurse—nursing and teaching
   b. The family—the unit of care
   c. Subjects taught by public health nurse
   d. Scientific aspects of family health supervision: Classifying all problems under "felt"* problems, physical and mental, or "unfelt" problems, physical and mental; the long-time plan for family health supervision; planning the nursing and teaching content of the day's visit.
   e. Psychological aspects of family health supervision.
   f. Aim of health supervision—intelligent self-direction of the individual and family of his and its own health.
   g. Accurate observance of basic principles of nursing with a thoughtful adaptation to the home of techniques taught in the classroom.

Conference II.

1. Teaching opportunities for the teacher-nurse.
2. Some principles and methods of teaching.
3. Aims of supervision—creative thinking, self-expression, intelligent self-direction with gradual elimination of close supervision. As applied to student—guidance, rather than dictation, of the student; helping her to think problems through for herself.
4. Objectives and content of daily supervision of the student by the teacher-nurse. Two rather detailed outlines were prepared by the assistant supervisors and the educational director to help the teacher-nurse with these conferences with the student. These are entitled, "Conference with a Student before and after Visiting an Old (to the V.N.A.) Case" and "Before and after Visiting a New (to the V.N.A.) Case."
5. Amount of supervision based on individual needs.

Conference III.

1. Selection of cases for a student—stressing continuity rather than variety of experience.
2. The case load.
3. The case study.

Conference IV (Held at the end of first month).

1. Evaluation of student work—why evaluate; criteria for rating.

One and one-half hours were allotted for each conference. For the most part, save when lack of time forced the lecture method on the leader, they were

*Felt means recognized by the family as important; unfelt means considered important by the nurse but not by the family or patient.

conducted in a very informal manner with free discussion which was always eager and thoughtful. Collateral reading was suggested but not required. Most of the nurses, however, seemed interested in outside study and a number made case studies. Each teacher-nurse had a student for four months, two months each, thus giving her experience with two individuals. Whenever possible the educational director discussed with each nurse the efficiency reports she made on her student.

In the material used for the teacher-nurse's conference with the student on an old case (that is, new to the student, but old to the field nurse), the items in the outlines serve only as pivotal points leading to further questions for the teacher-nurse to ask. As given here they are in rather rough form, being still in the "crucible of experience," and may seem unnecessarily detailed in spots which has seemed necessary until our teacher-nurses become more accustomed to their new responsibilities. The outlines are only intended as a general guide, not to be followed too literally. Occasionally, to save typing, the material in the second outline (conference on new case—new to V.N.A.) could be supplemented from the first outline, as under Outline II, questions 5 and 6 (after Visiting Case) could be broken up further by utilizing items I, C, 9 from Outline I.

OUTLINE I

Conference of Teacher-Nurse with Student—Old Case

I. Before the visit
- A. Fundamental health problems already discovered—(for each member of the family)
  - 1. Felt problems (recognized by the family)
    - *a.* Physical and mental health problems
  - 2. Unfelt problems (not recognized by family, but by nurse)
    - *a.* Physical problems, such as:
      - (1) Need for periodical physical and dental examinations
      - (2) Correction of defects—immunizations
      - (3) Adequate nutrition
      - (4) Health habits (desirable)
      - (5) Need for health knowledge—cause and prevention of disease
    - *b.* Mental problems, such as
      - (1) Infant and child guidance—behavior problems, etc.
  - 3. What problems seem most important to the family? Has family a plan?
  - 4. In what order should they be handled?
- B. Social and economic conditions affecting the health situation.
  - 1. Active with what social and health agencies.*
- C. Details to be stressed
  - 1. Name
  - 2. Address (floor, back or front, left or right)
  - 3. Make-up of the family
    - *a.* Economic and social conditions
    - *b.* Occupation
    - *c.* Interests, ambitions, etc.
  - 4. Immediate problem (nursing, teaching)
    - *a.* Attitude of the patient and family toward the situation and toward the nurse
  - 5. Nurse's name
  - 6. Doctor's name
  - 7. Doctor's diagnosis and orders
  - 8. Nurse's notes of treatment and advice to be observed
  - 9. Plan of visit
    - *a.* Introduction to home and patient
    - *b.* Details of nursing care (stress reading of bedside notes)—organization
      - (1) Preparation of equipment, patient and nurse
      - (2) Treatment (accuracy of basic principles, comfort of patient, speed and efficiency, a finished piece of work)
      - (3) Clearing up—patient, equipment, and nurse
    - *c.* Discuss importance of toilet tray and the use of a helper, teaching the helper, etc. (demonstration by student and return demonstration by helper)
    - *d.* Teaching visit
      - (1) Review of last visit's instructions
      - (2) New instruction—as planned or indicated by situation in home
      - (3) Summary of important items

In discussing the teaching part of the visit with the student such things as the teachability of the patient and family should be mentioned, how able family is to assume responsibility for carrying out orders, etc. Stress the importance of the psychological approach as well as the logical.

- D. Fee
- E. Plan with the patient for the next return visit

*It is important for student to study family histories and to acquire the habit of picking out for herself the health problems and what has been accomplished in reaching desired ends. A health problem is anything that needs to be done—a service to be rendered or health instruction or creating the right attitude toward health.

II. After the visit

It is important that the teacher-nurse be a good listener and draw the student out skilfully by questions. The student should be encouraged to think and plan for herself. Telling the student what to do is poor teaching.

A. Report of nursing care
1. Condition of patient—new orders
2. What evidences of nursing care during nurse's absence?
a. Did the helper have supplies ready for the nurse?
b. Was the toilet tray still intact?
c. Did it show evidence of being used by the helper?

In case a helper had not been found on the previous visit, did the student secure a member of the family to instruct, and assist with, the care of the patient?

B. Report of teaching—health supervision
1. Had advice given by previous nurse been carried out?
2. Did student review advice given by previous nurse?
3. Was she able to present and carry out her plans for teaching?
4. What new problems did the family present? Did it seem wise to drop own plans for consideration of new problems?
5. Did the student summarize the important teaching points of the visit? What were they?
6. How did helper, family, or patient receive the advice? Were they interested? What is the attitude toward health? What was the student's psychological approach?

C. Records and bedside notes (written clearly and concisely—complete as to information—avoid verbosity)
1. Condition of the patient—does account indicate the amount and character of change?
2. Progress made by patient or helper in following advice previously given
3. New problems observed and taken up
4. Advice given

D. Was there any need for reporting back to the doctor? Any need for reporting back to a social worker? Any need for referring to a social agency?

E. Any occasion for seeking assistance of any of the specialized supervisors, Hartford V.N.A.?

F. When should next visit be made? What preparation for it will be necessary?

OUTLINE II

Conference of Teacher-Nurse with Student—New Case

Before Visiting Case
1. Explain call slip—Has family been known to V.N.A. before?*
2. Pick out record forms needed—family folder, morbidity sheet, etc.
3. Name and address to be printed on face sheets of new records (complete address, floor, front or back, right or left)
4. Explain taking of history (method of approach depending on situation)
5. Call doctor for orders
6. If there is no doctor on the case. (How to secure free medical care?)
a. Take temperature, pulse, and respiration
b. Give partial care or full bath and alcohol rub, if conditions allow (condition of patient, temperature of room, etc.)
c. Latter care given only when doctor is called on the case
7. Fees
a. Advise student that she must learn to judge financial status of patient to decide whether V.N.A. will collect full or part fee or carry the case free.
b. Acquaint student with the insurance company manuals for knowledge to be obtained from the patient's policy.
(1) Explain service to patient
(2) Note number, date of issue, and P.R.B. on the record on first visit.
8. V.N.A. calling card—when to leave it

After Visiting Case
1. What did the nurse find?
2. How was visit organized?
3. What nursing procedures were used?
4. Were all doctor's orders carried out? If no doctor, what arrangements were made for medical care?
5. What preparation of equipment was made by nurse (toilet tray, etc.)
6. Was a helper selected and instructed in the preparation for daily care (morning and evening)
7. How was the nurse received? What impression did the patient make on her? Impression of home, sanitation, housekeeping, sleeping arrangement, nutrition, etc.
8. What was accomplished by nurse's visit? Did she attend to the needs as felt by the family? Did she attempt too much for one visit? What advice given?
9. Were full bedside notes left? Did student feel it necessary to report back to doctor?
10. What arrangements were made about the fee?
11. What health problems were noted? What social and economic problems?
12. When will case need to be visited again? Did student tell family when next visit will be due? Was V.N.A. calling card left?
13. Discussion of record and history (date—make-up of family, occupation, situation, etc.) Check all records carefully—folder and history.

*If the family of a new case has been known to the agency before, it is assumed that the student will study the history, having in mind familiarizing herself with the health history of the individual members of the family who have been carried before. As a guide to her study of the family she might follow the outline already given in Outline I, sections A and B.

HOW SCHEME IS WORKING

Some might think that such a scheme would deprive the student of much needed help from the supervisor. Safeguards were set up to forestall such an occurrence. The minimum number of field and office visits accorded each student by the supervisors and educational director was maintained and, since the supervisors gave the teacher-nurses special attention, the students really received more help than they would have had under the former plan of supervision. Each supervisor had three teacher-nurses in her district. Each morning after the teacher-nurse had discussed the student's plans with the student, both then presented them to the supervisor or her assistant. Occasionally when a problem arose that appeared to be of common interest, the supervisor would call all three of her teacher-nurses and their students together for an impromptu general discussion. In the main, the project has meant closer and better supervision.

As with most educational activities the staff has felt that there is not time in the day to make the very most out of all the opportunities such an undertaking presents. There may be danger that some teacher-nurses in a desire to protect their students may fail to develop desirable student activity in planning student work. When permanent teacher-nurses are selected at the completion of the project, continued supervision will be necessary to develop teacher-nurses who will be able skillfully to help students help themselves. But so far as the project is concerned, there seems to be a unanimous feeling that it has been worth while and stimulating. In preparing this article the writer held individual conferences with each supervisor and many of the staff nurses who had had the experience and invited frank criticism and appraisal of the project. The following summary of direct and indirect results fairly represents the consensus of opinion as to its value.

DIRECT RESULTS

The staff nurses know and understand the aims and content of the student program better than before.

Correlation between classroom teaching and field work is steadily improving.

The staff nurses have learned through experience something about supervision —the need for, its aims, and its methods of work. As one supervisor said, "You rarely hear now a staff nurse say to a student, 'You are supposed to do this.' "

INDIRECT RESULTS

The staff nurse is learning to turn an intelligent and critical eye upon her own activities—her nursing procedures, her teaching skill, as well as her knowledge of health facts, and on the managing of her case load. Many feel that their powers of self-analysis and job analysis have been sharpened.

The project has helped the staff nurse to understand the problems of her own supervisor.

The feeling of the staff nurse towards the student is changing from one of seeming indifference to one of interest and a conviction that in the teacher-nurse student relationship there is an opportunity for mutual growth.

What Shall the Public Health Nurse Tell Families About Buying Food?

By RUTH WHITE FISHER

Consulting Nutritionist, Public Health Nursing Association of Pittsburgh, Pa., Inc.

AS those of us visiting in homes know, many families wait until meal time to "go to the store" or send a child out with instructions to get "something for lunch." Too often the meals are not planned and excessive amounts of money are spent through careless methods. It is evident to public health nurses that many of the meals in the homes they visit need careful planning if the income is to cover the actual needs. The aim, therefore, in these homes is to teach the wise expenditure of money to the families in terms of values. Often their ideas of values have been gained through advertisements which give only part of the truth. It is, therefore, the responsibility of the educator to be well informed on scientific facts before giving advice. Various helps are available as guides, such as the publications of the Federal Government and well-known nutrition books. What are some of the points a public health nurse should be prepared to talk about?

WHEN TO GO TO THE STORE

Perhaps the first point to consider is the time the family should go to the store. Pay day has long determined the shopping day for the greatest supply of foods. How often have we seen the pay check exchanged for beans, flour, sugar, ham, ketchup, a few canned vegetables, tobacco, and some candy for the children! Eggs have been bought reluctantly and fruits and vegetables have been luxuries beyond the family's means. Families have been raised on this kind of food and have paid the price. However, this practice of going once a week or every two weeks for basic supplies is after all a sound economic practice and one to be encouraged, since it permits buying in larger quantities which is more economical—for example, a twenty-five pound bag of sugar or a forty-nine or ninety-eight pound bag of flour. The amount of fresh material purchased at this time depends upon what facilities the family has for keeping the foods, or how near the family lives to the store. Only the most perishable foods need to be bought frequently, such as meat, milk, fresh fruit and vegetables. It is an expensive habit to go often to the store because of the temptation to buy beyond one's needs and pocketbook.

WHO SHALL GO TO THE STORE

The family food buyer going to the store in person has the best opportunity for learning the selection of food.

The person who does the marketing varies with the particular family organization. In the foreign home, the husband usually spends the money. The American home seems to depend entirely upon the wife. Spending the income is a joint family problem, and education of various members of the family, either directly or indirectly, will accomplish the best results.

WHAT STORES

The choice of the store or stores will depend upon many factors, such as proximity, cash or credit basis, grade of merchandise carried and prices. It is advisable to select a "cash and carry" store when one is economizing. Credit and delivery are expensive. It is wise to watch competitive markets for the best values.

WHAT FOODS

The quality of the foods and the amounts are the most important considerations. Before any attempt is

made to advise about these matters it is well to ascertain the family's own choice for a week's supply of food, and the amount of money available for food. Any housewife should be able to give this information to the nurse. It is well to evaluate carefully before making any suggestions. For example, milk may be inadequately used, meats over-bought, or too few vegetables may have been used. To make this evaluation it is necessary to have some idea of the amount of foods needed each week if good nutrition is to be maintained; for example:

1 pt. of milk for each adult, per day
1 qt. of milk for each child, per day
4 eggs per person per week
1 lb. of meat per person per week
2 lbs. of fruit per person per week
2½ lbs. of vegetables per person per week
5 lbs. of potatoes per person per week
2½ lbs. of flour or 3 loaves of bread per week per person
1½ lbs. of cereals including rice and macaroni per person per week
1 lb. of fats per person per week
½ lb. of sugar per person per week
½ lb. of beans or peas per person per week

Let us take for example a family of five which bought:

15 lbs. of meats per week
5 lbs. of vegetables per week
7 qts. of milk per week
5 loaves of bread per day
5 lbs. of sugar per week
1 doz. of eggs per week
6 lbs. of fats and oils
2 lbs. of coffee
3 lbs. of beans

We can readily see that the family was underfed, both in the total amounts of food and the kinds of food. Too much meat was purchased, since 5 pounds would be sufficient, too few vegetables were used, not enough milk, too much sugar, too much bread and not enough eggs. Technically, the diet was low in protein, too high in fats and carbohydrates, low in minerals and vitamins. The public health nurse should know the dangers of such a diet.

Before making any suggestions, it is well to comment on whatever has been good in the selection made. It is often necessary to encourage the use of larger quantities of certain foods if health is to be maintained, and to discourage the use of excessive amounts of other foods. For example, it is necessary to point out the health consequences of too many fats and carbohydrates, and too small amounts of vitamins and minerals. The health value of an adequate diet should be taught along with the economies of such a diet. The objective with the family is to persuade the members to select the quantity and quality of food needed to maintain health within the limits of their income.

An order for foods of low cost* can now be estimated for any size family by using the outline at the bottom of the next page.

The above recommendations are for the minimum allowance which will provide adequate nourishment for a family which is in a good physical condition with no health problems, such as malnutrition, tuberculosis, or other conditions where extra nourishment is needed, and where the family is not doing even moderately heavy work. In such cases extra food is necessary.

It is obvious that certain practical variations are necessary, as, for example, for a person living alone the cost of foods is higher per person than in a larger group. Expectant and nursing mothers need more food. Heavy activity requires much larger amounts.

For more complete information about amounts of foods needed, the publication, *Diets at Four Levels of Nutritive Content and Cost,* by Hazel K. Stiebeling and Medora M. Ward, published by United States Department of Agriculture, Circular No. 296, is the best guide at the present time.

Thus, we see that a family of five composed of two adults who are not doing strenuous work, one child of five years, one of nine, and one of fourteen years, needs approximately each week the following food:

**Minimum Budget for the Client Family,* Committee on Family Budgets of the Pittsburgh Federation of Social Agencies, 1931.

Milk	24½ qts.
Eggs	1⅓ doz.
Meats and Fish	4 to 5 lbs.
Fats	3 lbs.
Fruits	7 lbs.
Potatoes	18 lbs.
Vegetables	10 lbs.
Bread or Flour	12 lbs.
Cereals	5 lbs.
Beans or Peas	2 lbs.
Sugars	2½ lbs.

NUTRITIVE VALUE AT LOWEST COST

This gives us a grocery order to use each week in this particular family. The selection of the best food values at the lowest costs is now the problem. In this, the public health nurse should be helpful. Let us visualize the mother of the family, purchasing the food.

Before she enters the store, she considers her budget and knows that it does not allow for prepared foods. As strict economy is necessary, only unprepared foods should be purchased, such as flour, instead of bread or crackers, or cracked wheat instead of prepared wheat cereals. For economy's sake, mere convenience will have to give way to nutritive values.

Fresh vegetables and fruits, especially the newest in season, are usually on the counter nearest the door and appeal to the customer. This is where her selection will depend upon her food knowledge. The price of a vegetable or fruit does not determine its food value. She must thoroughly appreciate this fact.

Before she buys anything she will have considered what portion of her weekly supply it is wise for her to buy. It is usually advisable to buy only two or three days' supply at one time. For her family of five, she needs eleven pounds of vegetables and ten pounds of fruit. Perhaps today it would be well to buy the following portion of that:

1 head of cabbage—2lbs. 2 lbs. carrots	4 lbs. vegetables (half root and half green)
1 dozen oranges—4 lbs. 3 lbs. apples—3 lbs.	7 lbs. fruit

It will be necessary to return to the store two or three times that week for the rest of the vegetables and fruits.

Her choice will depend upon the condition of the food, its food value and its price. If brussels sprouts are for sale as well as cabbage, she will choose cabbage because it has about the same food value as brussels sprouts and sells for a lower price. If oranges and tomatoes are for sale, she will buy the cheaper, but only after she has asked the price of the canned tomatoes. She may buy canned tomatoes when they are cheaper than either oranges or fresh tomatoes. After the citrus fruit is purchased, she will buy the cheapest fruit displayed, which will probably be a seasonable one. Size of fruits determine to some extent the price but not the food value. When all fresh fruit is very expensive, she will purchase only the citrus fruit that is necessary and buy the rest of the fruit dried.

THERE ARE POTATOES AND POTATOES

Potatoes are also found at the same counter. There are great differences in potatoes, such as variety, condition and

---

LOW COST FOODS APPROXIMATELY REQUIRED FOR EACH WEEK

Foods	Infant to 1 year	Child 1-6	Child 6-12	Child 12-16	Adult
Milk or equivalent	7 qt.	7 qt.	7 qt.	3½ qt.	3½ qt.
Eggs	7	4	4	4	4
Meats and Fish	—	½ lb.	¾ lb.	1½ lb.	1¾ lb.
Fats—Butter, Oil, Lard, Bacon	—	¼ lb.	½ lb.	1 lb.	1 lb.
Fruits—Citrus					
Fresh	7 oranges	2 lb.	2 lb.	2 lb.	2 lb.
Dried	½ dried				
Potatoes	1 lb.	2¼ lb.	2½ lb.	3½ lb.	5 lb.
Vegetables—Root, green	1½ lb.	1½ lb.	2 lb.	2½ lb.	2½ lb.
Flour and Bread	—	2 lb.	2¼ lb.	2½ lb.	2½ lb.
Cereals	¼ lb.	½ lb.	1 lb.	1 lb.	1½ lb.
Navy Beans	—	—	¼ lb.	½ lb.	½ lb.
Sugars	½ can Karo	¼ lb.	½ lb.	½ lb.	½ lb.
Cod-Liver Oil	4 oz.				

age. The mother will want a smooth-skinned, medium sized, firm potato. It is usually more economical to buy potatoes by the bushel if it is possible to store them at home. Sweet potatoes may be used for variety, if they are cheap and good. It is a good plan to ask the grocer to cut open one of the lot of potatoes that is being considered. "Hollow heart" or "black heart" are defects which cannot be detected otherwise. In winter potatoes there may be a dark ring under the skin which comes from freezing and usually affects the flavor. They turn dark in cooking, too. Potatoes which have a greenish color on some part of the surface are those which have been sunburned. These are usually too bitter to eat. Wilted, sprouted, and cracked potatoes should always be avoided.

DAIRY PRODUCTS

She next approaches the dairy counter. She will have to decide what grades of fats to buy. Shall she buy oleomargarine or butter? If she wishes to economize she can select oleomargarine if she uses plenty of green vegetables. Butter, however, usually has a more acceptable flavor. There are many grades of butter sold. For particular purposes, butter should be sweet, fresh, clean, and have good body and color. Usually a store consistently purchases the same grade of butter.

Eggs, to be first class, should be clean, have sound shells, localized air cells not more than one-eighth inch in depth, the yolk may be dimly visible, the whites must be firm and clear and there must be no visible development of the germ. Supply, size, as well as the age of eggs, also enters into determining the price.

Milk may be purchased from the store. Let us assume that our mother does purchase it there. The question to decide is whether to buy Grade A or Grade B, bottled milk or evaporated milk. In order to decide we must know about the relative qualities of the milk. Grade A is higher in butter fat than Grade B, being about 4.5 per cent while Grade B must be at least 3.5 per cent to conform to most state laws, although the average kinds have 3.7 per cent to 3.8 per cent. The bacterial count of Grade A milk shall not exceed 100,000 bacteria per c.c. before pasteurization and not over 10,000 per c.c. at time of delivery. Grade B milk shall not have over 1,000,000 bacteria per c.c. at any time and not over 50,000 bacteria per c.c. at time of delivery.

Grade C is usually sold loose for bakeries and cooking. The law requires that the bacterial count shall not be over 50,000 per c.c. at time of delivery.

Certified milk produced under the most exacting sanitary requirements reaches the customers as raw milk with a bacterial count ranging from 2,000 to 8,500 bacteria per c.c.

Canned milks, as we know, vary in sugar content. It is advisable to use the unsweetened when used as the only source of milk. Although there is some destruction of vitamins by heat, the difference is negligible, we are told. At certain times fresh milk is cheaper than canned milk; at others, canned milk is cheaper. The customer makes the decision after evaluating his needs.

CANNED FOODS

Canned foods are usually more expensive than fresh seasonable foods. There are grades of canned foods, but the label cannot be depended upon for the grade. The weight is required to be stamped on the label. Certain industries have their own grades or brands which are not always reliable. Supply of foods as well as grades influence the prices also. Larger containers are always more economical. There is much more work necessary to protect the consumer in the purchase of canned goods.

As the mother approaches the grocery counter she sees such divisions as canned goods, packaged cereals, and dried fruits. They are so inviting that she is tempted to buy without thinking. There are the nice labeled fruits and vegetables: rows of cans with pictures of luscious fruit, apricots, peas and corn.

But she stops to consider. A can of King Supreme cherries containing 11.5 ounces costs 17 cents or 24 cents per

pound, while the fruit counter shows nice fresh cherries at 10 cents a pound. A can of peas comes to 13 cents per pound (cooked measure) as compared with 10 cents for a pound of fresh peas in the pod. The fresh food seems the best buy economically as well as nutritionally.

At the same counter she has to consider the cost of canned baked beans. She would have to pay 10 cents for a pound can of baked beans. From this she could get four one-half cup servings. If she baked the beans, she would buy one pound of navy beans for 5 cents; in the cooking she would use about 5 cents worth of bacon, molasses, and ketchup to season, and to bake she would use about one cent's worth of gas. From this she would have twelve of the same size portions. Figuring further, the canned beans would cost 2½ cents per serving and the home baked beans cost less than one cent per serving. Convenience would have to be sacrificed to economy.

Dried fruits are graded into five classes, Extra Fancy, Fancy, Extra Choice, Choice, and Standard, depending upon the size and condition. The smaller fruits yield the most food value for the money.

CEREALS

The selection of cereals involves thought on the part of the purchaser. Our buyer must consider the composition and costs of some of the cereals. Whole grain cereals such as cracked wheat, cut oats, whole grain corn meal, bought in bulk, are the cheapest forms of cereal and contain the maximum amount of food nutrients. The price ranges around 5 cents a pound. There are several whole grain cereals sold in packaged forms which in every instance are three or four times more expensive than the bulk cereals. There are others which contain only the bran and endosperm or starchy portion of the grains and not the germ, and still others which are only the endosperm. Puffed wheat and corn flakes are examples of the latter. The average price of puffed wheat is about 40 cents a pound and corn flakes about 17 cents per pound. Almost all prepared cereals are far more expensive and not so nutritious as the whole grains.

The question of flour depends upon what use the family is to make of it. The spring wheat flour lends itself to bread baking and the winter wheats are better for cake baking. Prepared cake and pastry flours are expensive foods. Whole wheat flour is often more expensive than white flour, which is unfortunate. Cracked wheat may be used with white flour for bread baking.

Bread and pastries sold in the stores are more expensive for the food values than those which are made at home. Often too much of the food budget is spent in cakes and pastries. Sugar is often overbought. Molasses having some of the minerals is a nutritious, cheap form of sugar.

MEATS

The selection of the kinds of meat is quite a problem. First of all we have the choice of buying fresh or prepared meat. If we analyze the values and costs, we find that prepared meats are expensive. In selecting fresh meats it is wise to go to the meat counter with an open mind, to see what kinds of meat are the best values that day; sometimes it is beef, sometimes pork, sometimes lamb. There are many local and other factors influencing this condition. The grade of meat which is carried by a store is fairly constant. Some stores buy a better grade than others. "Medium" grade makes up the bulk of the meat trade. The meat is firm, rich in proteins, and an average priced, nutritious food. The cut of meat is the next consideration. It is obviously unwise to buy expensive steaks and chops when one is economizing but it is also unwise to pay "lean meat" prices for fatty and gristle tissues. The legs, such as round cuts, and shoulder, such as chuck, are the best values for the money usually.

OTHER FOODS

Often too much of the family's money is spent for tea and coffee. The food value is negligible. It may be imprac-

ticable to advise the family to discontinue the use of these entirely, but it is wise to study the proportion of income used for such foods.

The so-called "health foods" cost much more than the same food nutrients in other foods. It is unwise to invest in these except in cases for which the family physician orders special foods.

After the mother has selected the foods and learned to use a food guide, it is well for the nurse to ask her to watch for such evidences of good nutrition as better health, healthier appearances, and happier dispositions in members of her own family. Patience on the part of the nurse is required, much more so than in the treatment of many diseases. A year or more may pass before the results of better nutrition will be apparent, but the result is worth waiting for.

TURN BACK THE CLOCK

Geneva Hoilien, Director of the Albany (N. Y.) Guild for Public Health Nursing, sends us these excerpts from the Albany *Medical Annals* of June, 1898:

"The *Annals* is again privileged to call attention to the work and purposes of the Albany Guild for the Care of the Sick Poor. . . . That the Guild fills a place in the medical practice of the city was revealed in the unstinted commendation given at the meeting of the County Society by physicians familiar with its purposes. With the assistance of the Guild the physician's work among the poor is not only lightened, but becomes more effective. Beyond this is an opportunity for the centralization and organization of charity with almost unlimited possibilities. The *Annals* commends the Guild to the physicians and citizens of Albany, and its scheme of organization and administration to other cities less fortunate than Albany in this particular line of work. . . . ."

And in a letter from the Secretary of the Guild to the President of the County Medical Society in 1898, we read:

"It will be seen that the Guild not only gives competent care to the very poor, but also enables those who are unable to pay the regular rates for trained nurses to receive professional care from the visiting nurses at a very moderate charge for such service.

Realizing that the work as so planned cannot reach its highest possibility of usefulness without the coöperation and cordial support of the medical profession, the managers would respectfully call the attention of your society to the following points:

1. The value to both physician and patient of the wider application of trained nurses.
2. The opportunity given the district nurse to enforce better sanitary conditions in the homes of the poor; the work thus being preventive as well as curative.
3. The disadvantage to physicians—in much of their gratuitous service to the poor—in the utter disregard of orders, and the counter-advantage of knowing that under the direction of the Guild instructions will be carried out with exactness by trained professional nurses.
4. The saving of time in the more rapid restoration to health of the patient and the saving of expense in the fact that the Guild can supply nourishment, tonics and prescriptions when it is found that it is impossible for the family to make such provision.

On the other side of the question, the advantages to the Guild in having the support and recommendation of physicians cannot be over-estimated."

A resolution was then passed by the Society:

"*Resolved*, That the Albany County Medical Society hereby endorses the work of the Albany Guild for the Sick Poor, and its Department of Visiting Nurses, as set forth in the communication and accompanying circu'ars laid before the society, believing that in the care and treatment of needy persons, the assistance of qualified nurses as indicated, is in accordance with the requirements of modern practice; and

Resolved, That these resolutions be inscribed upon the minutes of the society, and that a copy be sent to the Albany Guild for the Sick Poor, for such use as is deemed suitable by the Guild."

Owing to illness, Miss Hazel M. Keene has been unable to prepare the article promised for January on the preservation of human milk. This was to be the continuation of her article describing the work of the Directory for Mothers' Milk in Boston, which appeared in our December, 1934, number. We hope that Miss Keene will be able to prepare the material for our readers in a forthcoming number.—*The Editors.*

A One-Day County Institute for Midwives

By LAURA BLACKBURN, R.N.

State Board of Health, Columbia, S. C.

TO meet the need for better and more practical training for the midwife working in isolated rural sections where doctors are fifteen miles away and money scarce, the one-day county institute is being used in South Carolina. We have been conducting classes for midwives, but never before have we had an opportunity to give them a whole day of connected demonstrations.

Where there is a county health nurse, she arranges for a suitable place and collects the necessary, simple equipment, a list of which has been previously sent her. A notice is sent each midwife in the county, telling her to bring lunch and a cup and be prepared to stay all day. A local group is asked to arrange for hot or cold refreshments, as the season demands. The county relief organization in many counties has paid for these refreshments and has provided a new bag lining for each midwife.

Where there is no county nurse, the relief organization has allowed one of its social workers to do this preliminary work. If this is not possible, the president of the midwife class makes the arrangements and collects the things. The best institute which we ever had was arranged in this way. The equipment is simple and as nearly as possible like what we would expect the midwife to get in a cabin in the country.

The equipment consists of a bed, mattress, two pillows and pillow cases, three clean sheets, oilcloth, table, chair, improvised stove, blanket or quilt, two towels, quantities of newspapers, clean rags, kettle, dishpan, iron, two half-gallon fruit jars, a pint jar, enema equipment, needle, thimble, thread, slop jar or bucket, one set baby clothes made from flour sacks, box or basket for baby's bed, piece of clean blanket for receiving baby, mosquito netting, bucket for water, pan or box top and mayonnaise jars for baby's tray and two basins.

I usually arrive at 9 a.m. with the adult Chase doll known as "Mrs. Chase" and the baby doll. "Mrs. Chase" is put in a tousled bed and the baby put behind the scenes. The room is purposely disarranged. A hasty check of materials is made and a last glance to see that the room is in a more or less natural state of disorder.

MEET MRS. CHASE

By this time the midwives begin arriving and much curiosity and interest is shown in "Mrs. Chase." There is usually much laughter and joking. They are highly entertained by their own wit in holding conversations with her. However, we are soon ready to start, but never right on time. The meeting starts with the singing of spirituals, prayer, a short talk by a doctor, a registrar, and a club woman. The roll is called by class groups and a red ribbon pinned on the breast of the class president whose class has the largest number present. This breast swells amazingly to meet the new responsibility.

We then are ready to start the series of demonstrations. This is supposed to be as nearly like a real delivery scene in the home, throughout, as we can make it. It calls for much imagination but the Negro midwife will never fail you in that respect. I act as the midwife, and to the astonishment of a midwife in the audience take her bag to use in the case. Several supposed neighbors are sitting around the room. I act as if it were a real case, greet Mrs. Chase and tactfully ask the neighbors in their own parlance to "Please excuse the room," reserving one intelligent one to help me.

We then begin putting things on to boil, the kettle of water, the dishpan

with the glass jars, etc. My hands are ostentatiously washed. We ask Mrs. Chase where her things are, when her pains started, etc. We clean the room and arrange it, consulting the audience at each step. We explain as we go. Mrs. Chase is given an enema, placed in a chair and given things to take her bath. The helper makes three newspaper pads and irons them. The baby's bed, clothing and things are fixed. Due to the constant questions and answers each step takes quite a bit of time. The time element in the stages of labor is shortened, however, as Mrs. Chase is supposed to be progressing rather quickly. We get her in bed with a clean pad underneath her (we have to save on sheets). I then do a good handscrubbing act, and give her a local bath. You can always count on a reaction from the audience when the clipping takes place, as this is one of the hardest things we have to teach in rural sections. An improvised bed pan is made of a strong biscuit pan with a small board wrapped in a newspaper across the end. There is usually considerable merriment over this bedpan. A freshly ironed perineal pad is put on and Mrs. Chase put up in a chair and her bed made. She is then put back to bed and watched for signs in the progress of labor. The audience is constantly questioned. A clean delivery gown is used and a simple technique continues, stressing the need for cleanliness and constant washing of hands and soaking in lysol. When the membranes are supposed to rupture the bed is cleaned by using a clean pad, or mopping the old one with clean rags and putting a clean ironed rag under Mrs. Chase. The delivery is talked through and as soon as the baby is supposed to be born, we stop for lunch. One hour is used for lunch and social conversation.

AND BABY CHASE

At 2 p.m. we start again. Baby Chase has been put in the bed with a piece of bandage tied around the waist, the other end leading into the reservoir of Mrs. Chase to represent the cord. As we call the meeting to order and pull back the sheet, the midwives always rise to their feet in their interest in the baby. We explain that there has been no intermission, and go ahead with the cutting of the cord, putting drops in the eyes, oiling the baby and so on. We usually stop here and demonstrate what to do in case the baby does not breathe. The afterbirth is usually stubborn about coming, to give us a chance to show what to do. After it is supposed to be delivered, we examine it—a torn paper bag can be used for this. Mrs. Chase is given after care and the bed cleaned. Before we are through, poor

These three had the best bags at the Institute

Mrs. Chase has to have a hemorrhage and a convulsion and be treated, but by 4 p.m. she is clean, quiet, and in good condition, though she has to be watched. The room is then cleaned and, if we have time, we bathe the baby.

The midwives are then asked if anything has been used which a patient could not get if she started in time to prepare for her delivery. Some answer "No," others murmur to those sitting near them. It is impressed upon them that this has not been a show for their pleasure, but to teach them just what we want them to do on a case. Each expresses herself as "glad I come today and I sho' is learned a heap." They find out we have had a hard time financing "Mrs. Chase," and come forward bringing nickels and dimes to "pay on her, as she done us a sight of good, and we sho' is enjoyed her too."

We have had twelve such county institutes and plan to continue until each county in the State has been covered.

Nurses Employed and Communities Served by Georgia E. R. A.*

By ABBIE R. WEAVER, R.N.
State Supervisor of Nursing Projects, Department of Public Health, Georgia

WHEN projects of all kinds were being set up by the Federal Government to provide work for the unemployed, the director of Women's Work under the Emergency Relief Administration sought ways of putting nurses to work and by so doing hundreds of men, women and children in Georgia have, during the past year, been given nursing service for the first time. Between October 1, 1933, and October 1, 1934, approximately 700 nurses have been assigned to various types of nursing projects; 238 nurses have been used on county nursing projects, where they have, for the most part, given bedside nursing care on a visiting basis to the sick in families on relief; 105 nurses have served at different times on a statewide child health project administered by the State Department of Public Health; 18 nurses have been assigned as industrial nurses to the canning plants; 59 have been used in various types of health surveys and 64 as general duty nurses in hospitals. In addition to this group whose service has been made available to public health organizations and hospitals, 142 nurses have been employed as private duty nurses on an hourly or daily basis to give care to patients who were critically ill in families on relief. A number of nurses have been used for services other than nursing: 8 as county relief administrators, 18 as aides, and 6 as clerical workers. An additional 15 have been assigned to a variety of projects, some as supervisors of sewing rooms, supervisors of lunch rooms, and for teaching of health classes. Within the year a total of 673 nurses have been employed. The number of new nurses assigned within the past month would make the number well over 700 to date.

In addition to this number of graduate nurses given employment, 94 practical nurses have been used as visiting housekeepers or for the care of the sick where such service as they could give was adequate.

These graduate nurses have been drawn from all parts of the State and have been chosen on the basis of need as certified to by the Relief Administrator. *Need for employment* has been the first consideration in the choice of workers. The work thus made available has not only enabled some 700 nurses to remain independent, but their earnings have, in many instances, been the only source of income for families who would otherwise have been dependent. These nurses are now serving practically every county in the State.

STATEWIDE CHILD HEALTH PROJECT

The largest nursing project is one which was inaugurated early last February, through the coöperation of the Federal Children's Bureau, the State Department of Public Health, and the Emergency Relief Administration. A statewide child health project was created to give health supervision to mothers and young children. This project provided for the services of 40 nurses, 26 to serve as child hygiene nurses, 10 as tuberculosis nurses, and 4 as district supervisors. Because of the enthusiastic response of communities to this project and the urgent need which was found for the type of service thus provided, the staff was doubled on July first and this increased group of eighty nurses distributed as follows: 62 to child hygiene service, 10 to the tuberculosis service, 6 as divisional supervisors, and 2 as statewide supervisors. The emphasis continued to be placed upon ma-

*Presented at the meeting of the Georgia State Organization for Public Health Nursing, Athens, Ga., November 6, 1934.

ternal and child health, the objective being health supervision for every mother and child in families on relief and in other homes where desired.

It is difficult to estimate the total accomplishment of this group. They have found their way into remote parts of the State, into mountain coves, swampy backwaters, and to the most isolated farmhouses.

The child hygiene staff is now covering 119 rural counties, a nurse being assigned to one, two, or three counties depending upon area and population. The tuberculosis nurses are covering practically every county of the State. Figures can, in only an inadequate way, give evidence of accomplishment. They do, however, give some idea of the quantity of services performed. In round numbers, the child hygiene staff has made 4,000 visits in the maternity service, 10,000 to infants and preschool children, has seen over 3,000 children in group health conferences, has taught 800 little girls enrolled in Mothers' Helpers classes, and given over 700 health talks to lay groups and school children.

Though immunization against communicable diseases was not a major part of the program, the nurses themselves have given in the past six months 78,000 inoculations against typhoid, 3,600 inoculations against diphtheria, and 1,500 smallpox vaccinations. In the tuberculosis service 116 clinics have been organized with the total attendance of 6,644 patients. Through these clinics 578 new cases of tuberculosis have been found. These cases have all been visited in their homes by the tuberculosis staff and plans made for either home or institutional care.

In addition to the services above listed, the child hygiene staff, early last spring, undertook to make a survey of births which had occurred in 1933. The Census Bureau at Washington became so interested in the effort that Georgia was making to check birth registration that a special fund was appropriated from national funds for a thoroughgoing study of birth registration in this State.

This group has concentrated upon the supervision of midwives; 369 classes have been organized and 894 meetings held; 2,558 midwives attended these classes. The importance of this service is apparent when it is realized that forty-two per cent of all the births of Georgia are attended by midwives.

The child hygiene staff also made a survey of crippled children and provided a record of some 700 children in the State in need of orthopedic treatment.

SPECIAL PROJECTS

Nurses have been used to make surveys of malaria in many counties and collected specimens of blood for diagnosis and have later supervised treatment through the administration of Atabrine. In two counties nurses have assisted with the survey of amebic dysentery and the drug treatment of the disease. Hookworm surveys have been made in a number of counties and hookworm eradication is now becoming a major objective in southeast Georgia. The services of 15 nurses are being used on a health survey in three counties, Cherokee, Glynn, and Randolph, where a complete medical examination is being made of all members of families on relief in order to have some idea of the health status of the average family and the expenditure that would be necessary if these families were to receive adequate curative and preventive medical service.

Recently a project on which the service of six colored nurses will be used has been started which will provide a school nursing service for six counties of the State.

INTERPRETATION OF SERVICE

No small part of the nurses' time has been used in interpreting to the communities the service they are prepared to give. They have made over 3,000 visits to physicians' offices and innumerable visits to public officials and lay people whose understanding and support they needed in order to make their work really effective in the community. This service has been in no small measure responsible for the fact that Georgia has

become public health minded.

This newly aroused interest has paved the way for the organization, which is now being set up in every county of the State, of a Child Health and Welfare Council. This Council will provide a permanent group of interested individuals in every community whose responsibility it will be to see that the gains made in the past year shall not be lost. The work of this council is to be divided into four parts—Public Health, Medical Service, Welfare, and Education. Already these councils are beginning to take an active part in sponsoring immunization clinics, corrective clinics of many kinds and to seek ways of financing medical care for which neither the Relief Administrator nor the parents can provide.

STAFF EDUCATION

The work of the administrative and field staff has been done under high pressure. Services have had to be developed quickly or not at all. There was no time for careful preparation of the staff for the responsibilities which were to be theirs. A three-days' conference of the entire staff was held last February in Atlanta at which instruction in the general principles of public health nursing was given. This instruction has been followed by a program of staff education through bulletins and conferences held from time to time in each of the six divisions of the State by the field supervisors.

In summing up the achievements of the Georgia Emergency Relief Administration in meeting the needs of nurses by enabling them to serve communities, I feel very much like a front line officer in a great war who is handicapped by being too near the trenches to give anything more inspiring than meager and somewhat incomplete statistics. Without exception the nurses have served with an admirable spirit, have met emergencies with a resourcefulness not to be expected and have served faithfully and unselfishly. There is no way of knowing the lives that have been saved by their service or the amount of illness prevented or of the increased health in many families. Letters of appreciation have come from families, administrators, and public officials.

Certainly one result of the nursing service has been a greater appreciation of the value of nursing service than has ever existed before, possibly because this service has been brought to large numbers of people who in the past have been deprived of it. So, although the lot of the nurse has been far from a happy one, when the books are finally balanced and the real history of these past four years written, the final appraisal will show, I believe, a surprising net gain not only for the nurse herself but for the profession she represents

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR JANUARY, 1935

The Speech Defective Child*

By MARTIN F. PALMER

Professor of Speech Sciences and Director, Flo Brown Memorial Laboratory, University of Wichita, Wichita, Kansas

IN speaking to various groups of people throughout the state since the creation of the Flo Brown Memorial Laboratory at the University of Wichita, I have often been surprised that the term, "the speech defective child," is not well understood. Thus in order to define this term I am going to describe a typical case to you.

Some years ago, a boy was carried into a laboratory of Phonetics and General Linguistics at one of our large universities. He was literally brought in on a stretcher. He could not stand or move his legs and arms, did not hear very well, could not see. He was twelve years old, and for twelve years all of his wants in life had been done for him. His parents, always seeking the illusion of hope, as parents will, had been here and there, trying everything. They knew, they said, that their boy was not an imbecile. He knew things. He reacted intelligently. Yet everywhere the report had been: "This is a hopeless imbecile. He should be put away." The Director of the Laboratory, a physiology research man, called from physiology to head the new work with speech defects, smiled in the way that only he can smile. He told those parents that he did not believe the child was either hopeless, or an imbecile. He made no promises, but asked them to put the boy in his charge. First, he was taken to an orthopedic surgeon. "If you can make this boy walk," he said to the surgeon, "I believe I can make him talk." To shorten the story: The boy walked. Four years later he was talking. What makes this story even more interesting to me is that I saw that boy two years ago. He was then a Junior at the University of Michigan, with an all A record. He was twenty-one. In nine years he had caught up in all his schooling. This much has come from the hopeless imbecile. The Director of the Laboratory was Dr. J. H. Muyskens, one of the pioneers in the scientific treatment of this problem, and an acknowledged authority on the speech defective child.

We have been describing Little's disease. The change in point of view in regard to the intelligence of individuals suffering with Little's disease has come about during the past fifteen or twenty years. And there is another story connected with this. Twenty years ago, the incidence of idiocy of children with Little's disease was set at 49 per cent, and in all of the medical texts of that period you will find some such percentage given. At another university of the Midwest, similar recognition of the significance of speech defects was given some fifteen or twenty years ago, and a laboratory created. The Director of the Speech Clinic became interested in these helpless, pitiable children, and talked to the Director of the Orthopedic Hospital. He asked him how many of those 49 per cent of Little diseased children could not talk. The Director was surprised. "Why," he said, "I should say nearly all of them." "Then," said this enterprising man, "why don't you let us work with them, and try to make them talk?" The Director of the Orthopedic Hospital was amused. "You can't make those children talk," he said, "they have nothing to talk about. Man, they're idiots!"

But this hardy gentleman persisted, and in the end he had his way. Slowly, with infinite patience, and with ineptitude due to inexperience they worked with those first children, delaying themselves months, and even years because

*An address delivered before the Public Health Nursing Section of the State Nurses' Association, Salina, Kansas, October 18, 1934.

of their mistakes, but in the end, one notable contribution was made: Out of those forty-nine idiots with Little's disease, about 47 are not only not idiots, but *the actual mental level is far above normal!* We do not know why this should be so, but the fact remains that it is.

INTELLIGENCE TESTS DEPENDENT ON SPEECH

This leads us naturally to a statement of fact that is often overlooked: Intelligence tests do not measure the intelligence of the individual, they measure merely his speech in one form or another. There is no exact intelligence test which is capable of measuring the intelligence of a speech defective child. It simply cannot be done.

Last year when working in Topeka, a sociology student came down from Kansas University to test intelligences. She wanted to make a measurement on one of my children with a speech defect who was coming to me from the Kansas Service Home and Placement League. Naturally, the Service Home called me and I asked them to send the young lady over to see me. When she came I asked her what tests she intended to give. She told me. "All right," I said, "the child will score about a ninety on one, and around 110 on the other." She was very much shocked. "That can't be," she said, "those two tests are standardized. They never vary more than six points from each other."

I asked her to wait and see and argue later. The next week she called me up and very much perturbed she was. "The child had a score of 95 on one performance test and 112 on the other test." She wanted to know what the trouble was with the tests. I told her there was none, she simply had tried to measure intelligence by a rather poor yardstick in this case. I advised her to wait six months until we had a chance to improve the child's speech, and that at the end of that time I wanted her to try again. This was done. The child scored 117 on the first test, and 118 on the second. I had asked her to revise the tests so she would be sure there was no memory repetition to aid the child. "What did you do to that child's brain?" she asked. "Nothing," I replied, "Your yardstick is simply better now, because the speech is getting better. You have again measured the speech of the child, and not its intelligence. I think that child has an intelligence of over 120 I. Q."

The moral here is obvious, and I want you to see it, as did that young lady. *Never accuse a child of being feeble-minded if that child also has a speech defect,* because you may be talking just about the speech defect and not the mind of the child. Understand we do not claim there are no feeble-minded children who also have speech defects. But we do claim that many so-called feeble-minded children are not feeble-minded at all, but merely speech defective, and that under proper training measures this fact can be demonstrated.

EFFECT OF SPEECH DEFECTS

This question of intelligence follows into the less serious cases as well. In the public schools for example, about three-fourths of the speech defective population are retarded one to six grades. A definition of education itself will show why this is true.

The normal child has his speech completely learned at three years. That is, all the tools are shaped. He has all the elements of language, plus the vowels and consonants. From three to five years of age he acquires some 2500 words, which are what he needs in his environment for the entrance to school. The first serious education is the teaching of reading. And what is reading? Reading is simply an invention whereby we are enabled to put our speech in permanent form so that others may hear us though separated from us by time and space. In other words it is an extremely clever and practical substitute for speech. And all our education is simply a development of this invention. Arithmetic, history, geography, etc., are all developments from reading. But what happens to the speech defective child in this situation? The teacher attempts to substitute a knowledge for a knowledge which the child does not

have. Thus at the outset, he is faced with a terrific obstacle. He fails in his first year. And then we have the spectacle of the child too old, and too big for his grade, thrown with younger and younger children. And we all know what happens to him. He becomes the problem child, with grave disorders in personality.

All speech defective children fall into two classifications in regard to their personality. First, the shut-in sensitive type, tight as a clam. You can see what happens to the school work of such a child. Let me give you a case. Last year, Genevieve was brought to me by Miss Minnette Peterson, the public health nurse in Salina. She had a cleft palate. It had been operated upon two years previously, but as is usual with such cases her speech had failed to clear up. She hung her head. Her eyes were dull, her hair unkempt. She made no attempt at personal neatness. "Is your name Genevieve?" I asked her. "Uh-huh," she said. Well, we worked faithfully with Genevieve all summer. Towards the last of August, Miss Peterson called me on the phone, excitedly, "What *have* you done with Genevieve," she asked. "I met her on the street, and she was walking down the sidewalk with her head in the air, her arms swinging, as though she owned the avenue. And when she passed me she called out, 'Hello, Miss Peterson.' "

Genevieve had not said a word aloud in school since the first grade. She had written everything, and had of course failed until she was four grades retarded at seventeen. At the end of the summer she had perfect speech, and I understand she is doing B grade work in all her subjects. She is a life reclaimed.

The second thing that happens to these children's personalities is this: They become the rebel type. One child came into my office, and seeing a picture on the wall, picked it up and threw it across the room. Understand this was not a distorted mind, not an emotional problem. This was a speech defective child with a good mind registering its hatred of the rut in which it was placed. In this connection it is interesting to note that the percentage of speech defectives among prison populations is very much higher than the normal.

NUMBER OF CHILDREN WITH DEFECTIVE SPEECH

We have been talking about individual children. But how many of them are there? Well, Wisconsin University estimates there are about 18 per cent in the total population. Iowa says there are 16 per cent, Michigan, about 14 per cent. A complete survey was made in the public schools of California some years ago, with the result that there are 9.5 per cent. A summary of the government survey of 1931, discloses that the government thinks there are about five or six per cent. Think of this. I talked with a nurse in a nearby county last summer about holding a clinic in her little city of about three or four thousand people. She said, "Oh, by all means come if you will, only to be honest with you, I think you will be wasting your time, because we have only three or four cases." I said I would come anyway. And the result was that I worked three full days all day long in the heat of this past Kansas summer, seeing children as fast as I could see them from eight in the morning till four in the afternoon. "You see," she said, "when I began looking for them they seemed to pop up right under my nose!"

Our position in all these cases is this: If the medical profession will accept the responsibility for correcting the tissue that is at fault in these cases, we will take care of this specialized function. We work with cretins, and mongoloids, after proper medical attention, also stutterers, of whom every hundredth child is one. In the stuttering problem we have not progressed as far as we should, simply because almost anything will relieve stuttering for a short time. Recently at Wichita University we demonstrated this truth. Explaining to some stuttering university students that the whole thing was merely an experiment and that we would proceed with the correct technique later, we told them that their left legs were shorter than their right ones, and that was why

they stuttered. We told them always to think about stretching the short leg, especially when stuttering, and they would stutter no longer. It absolutely cured them—for a few days! Thus this rather peculiar phenomenon has been responsible for the large numbers of stuttering schools throughout the country, most of them being run on an out-and-out exploitation basis. One charges fifteen hundred dollars in advance for a guaranteed cure, which does cure, but leaves the individual with a worse defect than the original stutter.

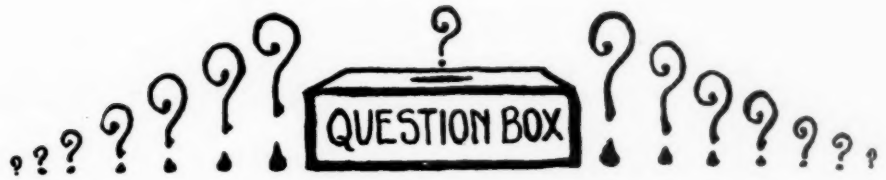
We do not know all about stuttering, but we do know these things: That changing of hands is a very bad thing for anyone to do, who does not understand the phenomenon, and that possibly eight or nine per cent of stutterers fall into this class. That the endocrine system is responsible in a large number of cases. That stuttering can be improved in nearly all cases, and in a large number can be corrected rather completely.

Cleft palate work also has been improved during the past few years. It is a field of which we are proud, owing to the fact that with better anatomical knowledge, and better surgical procedures, we have been able to raise the percentage of correction from about 6 per cent to around 85 per cent. This means absolutely perfect speech, with no evidence of nasality.

We also work with baby talkers, even though perhaps half of these may outgrow the defect. We endeavor to correct these defects before serious harm is done. If time permitted, I would go into the other problems of aphasia, reading disabilities, deaf mutism, and here let me remark, that we no longer teach the manual language to these unfortunates, and that it is possible to give good speech to every deaf child. Even individuals without larynxes, either as a result of operation or other causes, can buy mechanical larynxes, or can be taught to speak with the esophagus.

At the newly endowed Flo Brown Memorial Laboratory we are attempting to handle these problems. We have sufficient cases on hand to keep us busy for an entire year, but we are always glad to see new cases, and to recommend certain things to do and carry out.

We offer a new point of view, the results of scientific research during the past twenty years, and a message of hope to many unfortunate children. Although sound work in this field is still very new in this country, our knowledge has progressed rapidly, and is progressing. At Wichita University we have no theories to propound, but we try to use the best of all that is offered.



Have you a question about *any* phase of your work? Send it in to our question box and we will pull out the answer, send it to you, and print it if it is of general interest. Send your question on a post-card if you want to save postage. Address "Question Box," care of this magazine. Answers will have the approval of the National Organization for Public Health Nursing. Names of inquirers will not be used.

Locking the Door on Child Labor

By MIRIAM KEELER

National Child Labor Committee

MUCH has been heard of the "abolition" of child labor under the NRA codes. Tremendous gains have been made, it is true, but there remain whole sectors of child exploitation which have not been touched by the codes. There are forty thousand or more domestic servants under sixteen years of age, for instance, among whom extreme cases of overwork, underpay, and unhygienic living conditions have been disclosed. The codes do not apply to agriculture, even of the most commercialized sort.* Thus, when children eight and ten years old were sent into the onion fields of Ohio last summer to be used as strikebreakers at starvation wages, there was nothing in the New Deal to prevent this outrage.

There are uncounted thousands of children, some as young as seven or eight years, doing tenement homework early and late in industries whose codes fail to eliminate this practice—and some doing "bootlegged" homework in industries where it is forbidden, according to a recent investigation by the New York Consumers' League. Wherever industrial homework is tolerated, it appears that the low rates of pay result in endless working hours lasting far into the night, and the use of child labor. This has been shown to be true during the past year in the making of artificial flowers and feathers in New York; in the lace industry and fabricated metals industry (the latter includes mounting snap fasteners and hooks and eyes on cards) in Connecticut; in hand work on ladies' handbags in Massachusetts.

There are instances where the codes fail to give adequate protection, as in the iron and steel industry where sixteen-year-olds may be admitted to the most hazardous types of employment under the code; or the newspaper publishing business, where girls or boys of any age may deliver newspapers day or night and may sell them except at night. Although amendments including a minimum age of fourteen (twelve, for carriers already employed) were proposed by the NRA at a public hearing in June, they met with vigorous opposition from the American Newspaper Publishers' Association, and up to December first no alterations in the code had been announced, the newspapers remaining free to use their hundreds of thousands of child sellers and carriers.

Children separating strips of lace. They get two cents for thirty-six yards. Takes the four fifteen minutes to do thirty-six yards or sixty-four cents for eight hours' work! Ages five to nine

*In the single case of child laborers in sugar beet fields, a benefit agreement signed in November under the Jones-Costigan Sugar Act sets a minimum age of fourteen years and restricts working hours for children fourteen to sixteen years to eight a day for the next two seasons. These regulations do not apply to children working on their parents' farms.

MUST RATIFY THE CHILD LABOR AMENDMENT

Nevertheless the banishment of child labor in more than five hundred industries under approved codes has won the approval of the entire country, and justly so. But even this is temporary—for the period of the emergency only. For unless the Child Labor Amendment is ratified and Congress thus empowered to pass a federal child labor law, a return of child employment must be expected when the codes expire and employers are once more free to hire children and pay them as little as they please.

Ratification of the Child Labor Amendment, therefore, has been announced by the National Child Labor Committee as the theme for the observance of Child Labor Day, which takes place this year January 26-28. Twenty states have already ratified. When sixteen more ratifications are secured, the Amendment will become a part of the Federal Constitution, and the passage of federal child labor legislation will be constitutional beyond all question.

For well over a century, effort has been made to control child labor through state legislation, although early child labor laws did not exclude even the youngest children from industry, but merely regulated the hours and conditions of their work.

As Homer Folks, Vice-Chairman of the National Child Labor Committee, stated in a recent article published in the *Clubwoman:*

> 'Looking back upon these beginnings of state legislation, we realize that great progress has been made, though at a pace which the veriest snail would easily exceed. Most people perhaps are inclined to feel that the individual states have done a fairly good job, even if it has taken them over a century in the doing. Analysis of the present child labor statutes of our forty-eight states reveals, however, that even yet progress is far from uniform. While some states have forged ahead, others have lagged far behind in measures to prevent child exploitation."

Even today, the child labor laws of nine states contain harmful exemptions through which children under fourteen may work, in some cases in manufacturing industries, even during school hours. In eight states the law allows children under sixteen to work nine, ten, or eleven hours a day; and in eleven states it allows them to work until eight o'clock at night or later. Eleven states fail to protect children under sixteen from hazardous occupations.

As an illustration of what can happen under such chaotic conditions, the Census statistics of 1930 show a *decrease* of 59.3 per cent as compared with 1920, in the number of children under sixteen employed in the textile industry in the United States; but an *increase* during the same period of 23.7 per cent in South Carolina, and of 11.9 per cent in Georgia. In the face of this situation, Governor Ely of Massachusetts declared, late in 1932, that he would feel obliged to declare a moratorium on the comparatively strict labor regulations in Massachusetts unless some way could be found to relieve her of the competition of industries in states with lower standards.

STATE LEGISLATION LAGGING

But the states were afraid to take any decisive steps toward remedying the situation by individual action, even with the spectacle of millions of unemployed adults clamoring in vain for jobs while low-paid children flooded the labor market. In 1933, with adult unemployment presenting an increasingly grave problem, bills to raise the age for full-time employment to sixteen years were introduced in eleven state legislatures. They were rejected in New York, New Jersey, Connecticut, Rhode Island, Massachusetts, and Pennsylvania—the states where the sweatshop competition was most aggravated—and were passed by only two states, Utah and Wisconsin.

Not even the actual establishment of the sixteen-year minimum for employment under the codes has emboldened state legislatures to strengthen their own laws. For, again in 1934, although bills to raise the minimum age for employment to sixteen years were submitted in four of the nine states holding regular legislative sessions—New York, Massachusetts, Rhode Island, and South

Carolina (the last named applying to textile mill workers only)—they were defeated in every case. The prospect for maintaining code child labor standards through the enactment of laws by the forty-eight states separately therefore is practically nil.

HOPE IN THE NRA CODES

The NRA code provisions temporarily establishing sixteen years as the minimum age for employment in more than five hundred industries, on the other hand, were put into effect on a nation-wide basis within a few months' time, with the full coöperation of employers, state officials, and public. A check-up of the cotton garment industry in Pennsylvania made in 1934 by the State Department of Labor and Industry, revealed only two children under sixteen among more than twelve thousand employees. Yet this is the very industry where, only a year before, hundreds of child workers in shirt factories had gone on strike against wages as low as $1 to $3 a week!

In addition to the sixteen-year age minimum for general employment, the majority of codes also set a higher age limit, usually eighteen years, for hazardous occupations. These are sometimes specified, but more often are left to the determination of the code authority. In a number of industries especially hazardous or undesirable for minors, the eighteen-year age limit is extended to all employment, as in pyrotechnic manufacturing, wrecking and salvage, burlesque theatricals, and the quicksilver and slate industries.

The need for such protection is indicated by the enormous toll of industrial accidents, estimated at fifty thousand annually, among minors in the years preceding the depression and the adoption of the NRA. Only about a dozen state laws afford such protection to boys and girls of sixteen and seventeen years.

It may be pointed out in this connection that without the much-criticized eighteen-year age limit contained in the Child Labor Amendment, it would be impossible to continue the protection of minors over sixteen against hazardous occupations which is afforded temporarily by more than four hundred industrial codes. There is no intention of course of preventing non-hazardous employment up to the age of eighteen years. As a matter of fact, the codes (which may well be considered as a guide to possible federal legislation under the Amendment) through exemptions allowed in a dozen or so occupations, provide additional flexibility permitting the employment of children fourteen and fifteen years of age in certain types of non-industrial work such as retail stores, outside of school hours. The codes of course are not concerned with the casual neighborhood jobs which children find for themselves after school hours—much less with the household and farm tasks of children in their own homes, nor does the Amendment apply to these. Indeed, the term "labor" used in the Amendment has repeatedly been construed by the courts to mean "labor for hire." No case has been found in which it has been interpreted to cover a child's chores at home and on the farm. The Amendment therefore does not give Congress the power to regulate such home tasks nor to interfere with family life, even if it wished to do so.

The purpose of the Amendment is quite different—to make possible the protection of children from industrial exploitation. And that this can be done successfully through national action with results far superior to those obtainable through the halting and uneven progress of state legislation, has been demonstrated once for all by the NRA codes. If the NRA has shown child labor to the door, it might be said that the Amendment will put a lock on that door, and that federal child labor legislation under the Amendment will turn the key in the lock, barring child labor permanently from our national life.

The Story of Our Bag

By JANE ELIZABETH HITCHCOCK, R.N.
Meriden, Connecticut

At the request of the public health nurses in Georgia, Miss Hitchcock, almost a pioneer member of the staff of the Henry Street Visiting Nurse Service, New York, N. Y., consented to tell how the Henry Street bag, after which so many thousand bags have been copied, came into being. We are grateful to Georgia for sharing Miss Hitchcock's story and deeply indebted to Miss Hitchcock for this contribution to public health nursing history.

WHEN on the epoch-making morning Miss Wald and Miss Brewster walked amongst the tenement houses of New York City looking for sick to whom they might minister, I fancy that their equipment was very simple—a gingham dress, a sailor hat, and a small bag similar to those still carried by women marketing in New York today.

I think formal technique was an undiscovered country to the visiting nurse at that time, or we might say, technique consisted in giving to the tenement house neighbor, as nearly as conditions allowed, the same nursing care that one would give to her mother or friend coupled with hospital cleanliness.

One thing that early became routine was the daily eggnog for those who needed it as nourishment, and most of them did. The eggs, the fork with which to beat them, and the whiskey were safely stowed away in the bottom of the bag. The milk could usually be found in the home. Sheets, pillow-cases, nightclothes, etc., were tied into a bulky bundle and always played their part as equipment. This was all in those early days when the staff consisted of Miss Wald and Miss Brewster. When I reached the field, the personnel had increased to five, and their labor had been rewarded by the greatly enlarged number of patients. More patients, more eggnogs needed, and less room in our bags to carry them. Then we resorted to containers of malted milk for our Kosher patients, and made hot drinks of Anker's beef extract for the Christians.

We carried gauze, and cotton, a disinfectant or two, a towel, and a cake of soap. Please recall that this goes back many years and would not stand a present-day test in surgical technique. With Miss Wald as our leader, the spirit to do was there and, I think, probably counterbalanced some of the unscientific spots.

One custom we had that I feel should be classed as technique related to minor surgical dressings, leg ulcers, burns, etc. We took satisfaction in using such articles as the home afforded, teaching the mother to cleanse utensils, boil, dry, then fold in a clean, if not white towel, reinforced by clean wrapping paper and tied in a neat bundle. This we put into a corner of a drawer out of reach of small people. We felt that it was well for the mother to recognize that her own household articles could be made adequate to serve in time of stress. We rarely failed to get her complete cooperation.

This extreme simplicity did not last long, for the world was becoming aware of the benefits of asepsis and antisepsis and we nurses changed the equipment and technique of our bag service. We provided ourselves with a small-sized Boston bag, and found a firm in the city which made them for us, adjusting them to suit our needs.

It could hardly be called the design of any particular person, but rather the gathering together of ideas as presented by the nurses, ideas that sprang into practice as the occasion arose. Each of these bags contained the following articles:

THE HENRY STREET BAG OF 1900

Bag: Made of black leather somewhat like a Boston shopping bag but a little larger.

Lining: Made of heavy linen, which could be cleaned by using a damp cloth.

Stationery: Folded paper napkins, pencil, daily record sheets, large envelopes for records, small envelopes with H. S. S. address, straps of adhesive rubber tissue in a large envelope.

Instruments: Bandage, scissors, wooden spatula.

Bottles: (large) Alcohol for rubbing, (small) Tinct. green soap, 95 per cent alcohol, glycerine, Lysol or carbolic, brandy.

Small Jars: Boracic powder, ichthyol ointment, vaseline.

Large Jar: Green soap, small white enamel bowl, hand soap, nail brush.

Instrument Case: (made of brown linen) Glass catheter, rubber catheter, probe, groove director, small scissors, glass syringe, glass connecting tube, silver nitrate stick, hypodermic syringe.

Two Brown Linen Bags: (made with draw strings) One contained gauze and unbleached muslin bandages. One contained rolls absorbent cotton, gauze, toothpicks for swabs, apron and towel for nurse's hands.

Visiting nurses in other localities asked the privilege of purchasing our bags. This we gladly gave until the time spent in this young business grew to such proportions that it seemed best to put it into the hands of one person. Miss Mary M. Brown, a graduate of the Presbyterian Hospital and a volunteer worker at Henry Street, was asked to take charge of these appeals and supply the bags at cost price to visiting nurses.

Filling, labeling, listing, checking, billing, etc., was done at Miss Brown's home by Miss Brown and a friend. Miss Brown's energy in shopping for equipment, measuring and spacing for contents, considering comfort for the nurses in the shape and size of utensils, etc., has made a bag that lives on and continues to be an indispensable aid not only to the staff at Henry Street but also to many other nurses who are found carrying the H. S. S. bag even in distant lands. This exacting work was continued for several years until the settlement realized that they were using too much of the precious time of these two valuable women. So this little industry closed and an established bag manufacturer took it up and put the bags on the market.

THE 1935 BAG

The content of the bags carried by Henry Street nurses today is as follows:

Pocket 1: 2 oz. bottle of green soap
Pocket 2: 1 oz. bottle of 50% alcohol
Pocket 3: 1 oz. bottle of hand lotion
Pocket 4: 1 oz. dropper bottle containing 1 dram of ½% acetic acid
Pocket 5: Urinometer (wrapped in paper napkin) in glass tube
Test tube
Test tube holder
Pocket 6: Vial containing litmus paper
Jute envelope containing
6 tongue depressors
6 applicators
Pocket 7: Vial containing 12 toothpicks

Attached to Strap on Left End of Lining of Bag:
(a) Chain made of three large safety pins
(b) Chain made of three small safety pins
(c) One pair of scissors (surgical or bandage) (two pairs may be carried if nurse wishes)
(d) One pair of baby scales.

Pocket in Lining at Right End of Bag:
(a) Twelve paper napkins (folded with folded edge at top)
(b) Metal case containing hypodermic and two needles (in front of napkins)

Strap on Large Pocket in Lining in Front of Bag, Commencing at Right:
Space 1: Rectal thermometer in black rubber case or metal case with black top
Space 2: Mouth thermometer in metal case
Space 3: Emergency thermometer, corrugated case or metal case with red top
Space 4: One pair thumb forceps

Pocket in Lining at Front:
3 small paper bags, each made from one sheet of newspaper (may be carried if nurse wishes)
1 receipt book
1 press board envelope containing
1 family folder
3 morbidity records
3 maternity records
3 advice to mothers
3 manila envelopes each containing
1 sheet bedside notes
1 fee card
1 M.L.I. card
1 John Hancock card
1 manila envelope containing 6 sheets of bedside notes
½ note pad (bag size)
1 baby health station card
Daily assignment sheet
1 list of mothers' clubs
3 clinic refer slips
Current histories necessary for day's work

Floor of Bag:
1 white enamel specimen cup
1 can Sterno
1 enamel funnel
1 instrument case containing
  1 glass connecting tube
  1 graduated connecting tube
  1 douche nozzle
1 case containing
  1 rectal tube, size 30 F
  1 catheter, size 18 F
  1 piece rubber connecting tube, 12 inches long
1 case containing
  3 sterile cord dressings
  1 nine-inch length of cord tie pinned to bag
  1 roll absorbent cotton
1 case containing
  1 nurse's apron
1 sterilizing basin
1 nail brush
1 hand towel

"When the Tycos apparatus and stethoscope are taken into the district, they are to be placed in a cotton case and carried in the nurse's bag.

It shall be the responsibility of the supervisor to see that staff members are provided with a sufficient supply of dry towels for the day's work, particularly in cold weather.

Staff members are permitted to provide their own hand lotion, if they prefer to do so. If it is in liquid form it should be kept in the standard bottle."

Using a store window for a food display. Almost any grocer would be glad to stock his window with these cereals and allow such a sign to be used. A suggestion for May Day—Child Health Day. Courtesy of the Tuberculosis Committee of the Association for Improving the Condition of the Poor, New York, N. Y.

A similar idea could be carried out in a fruit and vegetable store; for instance, a selected display showing the fruits and vegetables—including milk—which build bones or teeth or help us combat infections, etc., etc. Advice from a nutritionist should be secured if possible. Such an exhibit offers a chance to interest local dentists and doctors in your program.

Utilizing Organized Groups in a County Nursing Program *

By AUGUSTINE B. STOLL, R.N.

One usually thinks of timeliness as a test of worthwhile material. An even greater test is timelessness. While this article was written in 1932, we only received permission to use it in 1934 and we feel that it is just as valuable now in 1935.—*The Editors.*

IN common with the rest of thinking people of today, we must seriously consider how economies of time, of service, and of money can be most safely arrived at in a county health department. We are apt to think of curtailment of a program as it is affected by finances, and to rush in headlong with the praiseworthy determination that by increased effort we will give the same service as formerly. This is impossible, and we should pause and consider where lies the greatest need for our services, whether we shall continue established practices, or, if they are well developed, relinquish the major interest in them to others and undertake services not adequately cared for. During this analysis, we should consider assets that we have not heretofore used extensively. We are not good salesmen and we are reluctant to talk of our accomplishments. It is the tradition of the medical group, and of its coworkers—the nursing profession—to do our job silently, as well as possible, confident that through its value it will prove itself. This is not true and we should shake off this threadbare belief. We cannot carry on a full program if we are financially limited, and if there are ignorance and doubt concerning the value of public health, this financial curtailment of funds will continue.

How many of us have heard vague remarks like this: "Oh, yes, I'm for the health department. It's a fine thing." How many of us have had courage to ask why the speaker is for it. Often he doesn't know; he has heard somewhere it had helped somebody. This isn't a positive stand.

All of this we admit, and the question still clamors for an answer. How shall we, unskilled in the methods of health education, untrained in coöperating with other organizations—how shall we reach out and arrest the interest and support of the average citizen?

First of all, comes the greatest difficulty in the problem: we must change ourselves, our point of view, become better informed of what others are successfully doing, and then do it. Too often we are carrying with us, as excess baggage, preconceived ideas or attitudes produced by old habits of thought. We escape behind the remark, "We give the people what they want," and ignore the fact that what they want may be what we have taught them to expect, and this may show little change or growth through the passing years.

The talk of health committees is bewildering to some of us. We are apprehensive of where they may lead us and are suspicious of this new thing. Yet, old ways are not working and together we must consider innovations if we are to continue to exist.

Our greatest apprehension is that committees • formed to disseminate knowledge and interpret our work to the communities, may grow too strong and become steering committees. Such steering or administrative committees

*Read at the Annual Health Workers' Conference, held in Jackson, December 12-14, 1932, by Miss Augustine B. Stoll, R.N. Reprinted in part with permission from *The Mississippi Doctor.*

conflict with the policies of the State Department of Health and could degenerate into groups representing factional interests and ambitions. May it be emphatically repeated that the suggested health committees do not belong to this class, and it is the responsibility of the director of the department to see them held to their own, very broad functions. In a recent medical magazine, an article stated that many states have reported that the county health departments that had been forced to discontinue were those that had little or no organized health committees.

FIRST STEPS IN ORGANIZATION

The word "organize" has a discouraging sound—how does one do it? First, let us consider a rural community with perhaps a small town of two hundred inhabitants. You will find that there is some form of organization already active there, perhaps several. Sometimes it's a small woman's club, a literary society, a parent-teacher association, or a patrons' union. Even in the smallest community, you will find the nucleus of what you are looking for. Get lists of all the members of the societies, men and women. See how many are members of several of the clubs, for that may mean public spirit. Consider them according to their availability in relation to the time they can give, their influence in the community, how they work with others, their vision, and their ability. Under this last heading, add their chief interest or activity. If possible, include in one of the committees the wife of the supervisor of the district, and also a representative of the teaching profession. This cataloguing of individual assets can best be handled through a card index, or the results may be tabulated in a notebook. Be assured that if time be spent in this way before a committee is formed, it will be many times worth it, through mistakes avoided. Get impartial opinion concerning those seeming to be best fitted for the work from reliable sources such as home demonstration agents, school principals, and outstanding citizens.

If the parent-teacher association is a strong organization, because of its connection with the school and because its members are from all social and religious groups, it is probably the best integrated organization that can be found. If it is selected, ask to meet with its members and discuss with them the forming of a health committee as part of their organization. Prior to the meeting, the director can submit a list of those selected and ask if the organization approve that these appointments be made. This gives to them the prestige of having been chosen by a county health department and predisposes them to coöperating attitudes. The chairman of these committees should meet with the director quarterly. These meetings may occur in each supervisor's beat, or in some other convenient division of the county.

In larger towns where there are several outstanding organizations, small health committees should be formed in each one according to the general method outlined. However, each organization will probably have a major health program, such as the Rotary Club or Masons program for crippled children. Use these established interests as assets and integrate them into a harmonious whole. See where duplication occurs and assist in eliminating it, guide the organizations without any chief interest into sponsoring certain phases of public health that may be neglected.

INTERPRETATION OF SITUATIONS

The chairmen of these small health committees should regularly meet and be kept in touch with the problems of the health department. This inner circle is one that should have greatest help, for they return to their organizations and pass on to them what has been given them. Very serious consideration should be given to the program for these meetings. Busy people should not give their time unless something worth while is given to them. The quarterly report of the department with its confusing array of statistics should be interpreted to them, showing what has happened in this county from a health point of view. Make them see figures as they relate to

individual cases with which they may be familiar.

Take your committee into your confidence. Explain what disease and death rates mean in relation to the nation, state, and county. Let them, as a county, find out where they stand. You will find that each section of the county has problems that may not occur in others. You may have a county with low marshy land and also hilly sections. Some portions will have clay soil and others sandy. Some parts will have satisfactory milk ordinances in force, while others will not. In town you will have sewage systems, and outside, the problem of small town or private sewage disposal. Consider their problems separately with them, and get a community pull behind a project. None of us likes too much theory or abstract ideas. We want something practical that we can go out and discuss in after-church groups or in front of a store counter. From these facts consider what the chief health needs are and how these needs are being met. If curtailment of any service must occur, decide with what correlated groups the division of responsibility can be made. Your committee will have excellent ideas about this and they will be able to make these adjustments possible far better than the health department and to achieve the desired end. Do not make the mistake of detailing to them simple things, but develop their sense of responsibility and then expect them to be responsible. Never fail to give them credit for their accomplishments.

BUSINESS-LIKE MEETINGS

Be prepared with an agenda for the regular meeting of the chairmen. Have copies of selected portions of the quarterly report with a narrative section ready for distribution to each one. As they become familiar with the ideas incorporated in it, point out increasing morbidity or mortality rates, possibly because of less funds available for the purchase of immunizing agents. Discuss the availability of sanatorium care as paid for through county funds against the cost and effectiveness of the Burr cottage.* Discuss nutrition in terms of school lunches and the need of pure milk for these malnourished children. Hookworm surveys can be tied up with sanitation. Topics are limitless and the interest and disseminated information are difficult to gauge. Some of these meetings should be county-wide and it would be wise to have all chairmen bring in a brief report of their most outstanding health accomplishment of the past year. Much is gained through this interchange of ideas and better knowledge of the problems of each other. This should be a social meeting and ease and friendliness best come about over a cup of tea and a bit of cake.

HEALTH CONFERENCES

Wherever it is feasible, the rural health committees should develop health centers and assist in their equipment, so that they may be prepared to care for all types of conferences or examinations held by the health department. Sometimes they can be located in a school or in other public places. In doing this they should understand the value of conference methods and how group teaching releases the nurse for further activities. In these centers, they can give valued assistance along the lines with which we are already familiar:

1. Getting the centers ready for the conference.
2. Transporting children and mothers.
3. Assisting with records.
4. Weighing and measuring.
5. A specially trained person can assist in the screening of testing vision and hearing for the nurse.
6. Getting the children ready for examinations.
7. Filling in records for the physician. Someone should be selected for this who will appreciate that these records are confidential.
8. Making out home slips.
9. Selecting pamphlets that interpret the findings of the physician to the home group.

This service frees the nurse that she may be everywhere, observing and assisting in the tests that are being made, and giving personal information regard-

*See PUBLIC HEALTH NURSING. January, 1933, page 19.

ing the child undergoing examination. Checking up on home slips, that they are accurate, and finally, discussing the condition of the child with the mother.

A newer service for the health committee following a conference is the evaluation of the service given at the conference. They must know the number of corrections of defects made, the changed régime of a child's living habits. This means home visiting usually with the nurse until the worker is better informed and as a result of this, activities start in communities to bring about the changes that need to be accomplished. Through these interested women, we can fling well out over the county a network that will reach each prenatal patient or neglected infant or child and get her under proper care.

HOW TO USE VOLUNTEER HELP EFFECTIVELY

Going to our card index or notebook, we hunt through it, finding out what special interests we have tabulated among the committee members. Here we have one who has studied typing and can get no work. When we ask her if she is losing her skill and speed, we often find she is worried over just that thing. She will be a rare person if she will not help us with some of our clerical work and indirectly keep herself in form. She can be taught mimeographing and can assist in preparing the quarterly reports for the central health committee. Others may want to keep up in dictation. Requests sent in to graduates of night school often bring results.

Some who are clever with their hands can take charge of supplies for the health centers and be responsible for a loan closet.

Occasionally, we may find some one who has a special talent for writing who may prepare excellent articles with local interest from authentic information. They also would be responsible for publishing news items concerning the activities of their own committees.

Those who can entertain successfully in their own home will be interested in planning exhibits, programs, and entertainments for their organization.

When we get people working along the line of their chief interest, or ability, they will be able to accomplish things we could never do. Several surveys are under consideration and certain of these women will be admirably fitted to assist in these. Not long ago, the conversation of two farmers was overheard. One said, "That sanitary inspector has been out to my house talking about those pit toilets—do you know he had my wife all worked up over it. She says we must have one right away." After a pause, he added, "It took me two days to quiet her down; but you know, when these women get started on a thing it usually goes through."

Add gradually to your card index another section containing the names of the people whom the health department has helped outstandingly. I recall a story of a health officer who said he had discovered that a child of a lawyer needed glasses badly. The father looked up the director and expressed his appreciation to him and then the father added, "Why, the little fellow has always been that way and we didn't know he couldn't see." When that officer has difficulties, he goes to that man and things mysteriously happen. We have all had experiences like that and we forget about them. But in time of stress such information could be turned over to your health committees and the services we gave, without thought, could come back bearing multiplied results—not to us, but for increased opportunity for service to others.

How Much for What

An Analysis of Cost of Visit by Type of Expenditure

FOR the interest of our readers we present the results of a recent statistical study made available to us through the courtesy of the Metropolitan Life Insurance Company. The financial statements submitted to the company by fifty nursing organizations with the same cost of visit for the year 1933 were analyzed, with a view to determining the part of the total cost of a visit for which each of the various items of expense is accountable.

It should be borne in mind that the figures given are averages based on the experience of the organizations studied. They are not to be regarded as official standards for general use, since the figures may fluctuate with local situations. Organizations will find the results of interest for comparison with similar figures based on an analysis of their own costs.

The distribution of the fifty nursing associations included in this study is as follows:

Size of Staff	*Number of Organizations*
1-4 nurses	26
5-9 nurses	11
10 or more nurses	13
Total	50

The percentage of the total cost of a visit which each of the cost items constitute is given below for agencies with one to four nurses, five to nine nurses, ten or more nurses, and for all of the fifty agencies combined. If the cost per visit is $1.00, the figures shown represent the actual cost in cents for each item. If the cost is $1.05, clerical salaries, for example, would cost 5.7 cents (which is 5.4 per cent of $1.05) in the 1-4 nurse agency, instead of 5.4 cents.

	Per Cent of Total Cost of Visit			
	Organizations with Staff of			All Organizations
Items of Expense	1-4 nurses	5-9 nurses	10 or more nurses	Combined
Salaries—Administrative	—	5.4	6.5	5.4
Clerical	5.4	6.5	5.4	5.4
Nursing	69.6	64.1	67.4	67.4
Student Nurses Replacement Cost	—	2.2	2.2	2.2
Total Cost of Personnel	75.0	78.2	81.5	80.4
Transportation Expenses	11.9	9.8	7.6	7.6
Nursing Supplies	3.3	2.2	2.2	2.2
Rent and Related Expenses	5.4	5.4	4.3	5.4
Office Expenses	2.2	2.2	2.2	2.2
All Other General Expenses	2.2	2.2	2.2	2.2
Total	100.0	100.0	100.0	100.0

TOO POPULAR

The business office is all out of the following numbers of PUBLIC HEALTH NURSING. Will any one willing to give any of her copies (if complete) to us for re-distribution, please send them to the N.O.P.H.N.—postage will be refunded. Needed:

January, 1932
January, 1934
February, 1934
March, 1934
April, 1934
October, 1934

Nurse-of-the-Month

ANNABELLE LESER

Mississippi

Annabelle Leser, R.N., is a native Mississippian, born in Holly Springs. She received her high school education at Yazoo County Agricultural High School, Benton, Miss., and went to work as a stenographer and bookkeeper, then the nursing profession beckoned to her. She graduated with honors from University of Tennessee School of Nursing, Memphis, Tenn., in June, 1930. The two following years she spent in Memphis in private duty nursing. In October, 1932, her wishes to practice public health nursing in her native state materialized and she has been affiliated with the Pike County Health Unit, McComb, Mississippi, as staff nurse since February, 1933.

Out near the Tangipahoa River is a cabin in the cotton where reside Marie and George. Until a month ago this was a lonely cabin. They had long wanted children in this home, but it seemed Marie had such trouble with her babies. Twice she had had miscarriages, she thought from stooping over sticking bean-poles. The last time she had thought they would really have a baby, and George had put the new ax under the bed to cut the pains, but the child had been born dead.

In the spring Marie heard of the "health doctor" who would examine her and advise her relative to the care an expectant mother should have. She walked five miles to the nearest health center to see this doctor and the nurse. Her blood was examined, and she learned that she would have to have a private physician give her periodic treatments in order that she might have a normal baby. She was given a book telling of the care she should have, and she and George studied this book together.

She took the treatments that the physician advised and when the time came, she had him deliver her instead of the Granny she had previously had to "catch" the newborn. As soon as the child was born she had George fill out the post card the public health nurse had given her advising of the birth of the infant so that the nurse might visit her. On the nurse's second postpartum visit Marie pointed with pride to the

George made this crib

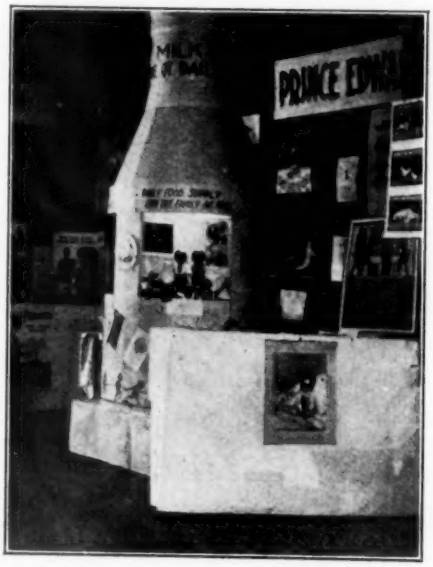
crib that George had made for the child after being told that the little youngster needed to sleep alone instead of with its mother.

On the last day of August when this little bit of sunshine for the Tangipahoa cabin was exactly four weeks old, Marie was the very first mother to greet the nurse and doctor at the infant and preschool medical conference. After getting the baby examined (and the physician found him to be normal in every respect), this mother went next door to her physician to have her postpartum examination, just as she had been advised to do at the Health Center.

Now Marie and George are spreading word in the community of the fine son they were blessed with because of the attention the mother and unborn child received at the Health Center from the doctor and nurse.

HEALTH IN A MILK BOTTLE

The picture shows a part of an exhibit by the Prince Edward Health Department at the Five County Fair, Farmville, Va. The whole exhibit included a fly trap; a manure bin with a fly trap window; a miniature bath room equipped with porcelain built-in tub, stool and basin all connected up with a septic tank and drainage field; a mosquito exhibit; dental posters and the equipment for a dental clinic in school. In preparing the exhibit of the work of the Nursing Service, I called in the VERA to my rescue and was offered the service of an expert workman to build the milk bottle that had been planned, and a local manufacturing company offered the use of their equipment in building the bottle—eight feet tall and three feet in diameter. The workman was allowed three days in which to do the job. He became so interested that time meant nothing to him and when the bottle was completed it not only was a work of art, but it was generally known that the Health Department was going to have an exhibit at the Fair and that Mr. Haga was building a milk bottle at Taylor's to be used in the health exhibit!



With the assistance of the VERA workers, we finally developed what many said was the "most attractive exhibit at the Fair." Food for the family was emphasized. The bottle was divided into four sections—daily food supply for the infant, for the preschool and school child and the family of five. Dolls were dressed to represent each age group and the foods suitable and necessary for each group placed on a tray in each section—milk and green vegetables always in evidence. On the back table we also stressed the importance of proper food for building good teeth and resisting the infection of tuberculosis. Trays with a quart of milk, green vegetables and fruits added to the attractiveness of this table.

Posters on a black wall and the white milk bottle towering eight feet high were in striking contrast to the rest of the colored booths and formed, therefore, an outstanding exhibit.

MAMIE E. RICE, R.N.
Public Health Nurse,
Prince Edward County, Farmville, Va.

Dialogue-of-the-Day

To our readers: Last year, we printed from time to time a page or two called "Our Own Readers' Digest" in which we tried to give, with extreme brevity, news on health problems of current interest. For 1935, "Dialogue-of-the-Day" will occasionally try to do this same thing. For January we have chosen

THE COMMON COLD

Public Health Nurse: "What's new that I ought to know about you, Common Cold?"

Common Cold: "Well (cough)—these facts: Vitamins D and A are my enemies. People who take cod-liver oil, and plenty of vitamin A in fruits and vegetables, are not so apt to catch me. And yet no one yet knows how I *am* caught—really! Scientists have not identified nor isolated the 'specific causative agency' of me. Vaccine is used against me sometimes with fairly good results—at least I can't attack quite so often or so heavily. One doctor has found that the removal of the uvula palate hinders my work—in fact, colds were reduced fifty per cent among his uvula-less patients. A lot of people are working hard on special diets, but so far nothing absolutely specific has been found to ward me off. The students at Cornell University, some of them (23 per cent), have me four or more times a year, some (17 per cent), only once—'cold resistant,' they call those boys. Winter is still my busiest season and I love rundown, tired, undernourished people. Wet feet and damp clothing, draughts and loss of sleep help me, too. Things I dislike are cool (70 degrees), well ventilated rooms, bodies well fed with citrus fruits, vegetables, milk, skins hardened to heat and cold, a clean nose and throat—all these conditions make it harder for me to attack. Some people use ultra-violet rays, but I can usually give them colds just the same. Immunity obtained through having me only lasts about eight weeks and I can start a fine trail of more serious diseases, especially pneumonia, on slight provocation. Of course, my most dangerous enemy is common sense. If people once really used that and went home to bed at the first tickle at the back of the nose, chilly feeling and sneezing, if they drank plenty of water, kept warm and quiet and alone for a day or two, taking plenty of fruit juices and eating lightly, well, then I wouldn't make so much headway, and if they sent for the doctor the moment any fever appeared, I wouldn't be able to get in so many mean consequences. As it is, I am still the greatest bane to society, costing the United States about $450,000,000 loss annually. I am still unpreventable! What do you think *you* can do about it?"

Public Health Nurse: "Use common sense and teach others to."

Common Cold: "Ugh!" (Cough).

Material for this dialogue gathered from the following sources:

Smiley, D. F., M.D. *The Prevention of Colds.* New York State Journal of Medicine, December 15, 1932.

Ewens, Arthur E., M.D. *An Overlooked Factor in Susceptibility to the Common Cold.* Illinois Medical Journal, April, 1934.

Beard, Howard H. *Prophylactic Effect of Vitamins A and D upon the Prevention of the Common cold and Influenza.* Journal of the American Dietetic Association, September, 1934.

Hitchcock, James, M.D. *Common Sense vs. the Common Cold,* Forum, December, 1931.

Common Colds and the Weather. Editorial, Journal of the American Medical Association, August 11, 1934.

Carter, William Wesley, M.D. *Common Colds: Their Treatment with Vaccines.* Medical Times and Long Island Medical Journal, May, 1932.

BOARD MEMBERS PAGE

Edited by KATHARINE BIGGS MCKINNEY

THE GUIDE-POST

Mrs. Dellenbaugh writing editorially on page 2 has put into words what has been in many of our minds and close to our hearts—a plea for a return to adequate recognition of professional service. As we heard one board member remark recently—"I'd rather see us curtail our service, limit our area, or drop a branch of our work, than ask our nurses to continue to take less money and work harder. As a resident of Blanktown and a contributor, I am in favor of *quality* of service. It is not fair to ask the nurses to bear the cost of our inability to interest the community to support the work."

Health insurance is a dream that has materialized in several countries abroad, and is being talked of here. How would it affect you personally and as a supporter of health service? See page 4 for some background information on this subject. The N.R.A. has not done away completely with child labor (page 26), let's marshal our forces! Treasurers will want to read page 36 and compare with their own services. We suggest page 11 for general interest and page 32 for rural groups. Another report on E.R.A. activity appears on page 19.

ALL TOGETHER

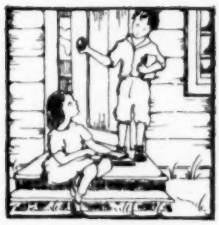
The plan to have all community chest agencies combine in holding an exhibition of their work has been increasingly popular. Detroit, Cleveland, Providence, San Francisco and Berkeley among other cities have tried out this method of calling attention to their social and health activities. Mary G. Taylor, Director of Public Health Nursing of the Berkeley Health and Visiting Nurse Association, writes about the exhibit it staged:

"The exhibit was in the men's gymnasium of the University of California. Our display consisted in an array of improvised equipment for the care of the sick in the home. A flour sack layette, an orange box bed tray, a home-made wheel chair, a steamer for hot compresses, a child's pot from a coffee can, bed rests of various kinds, and a home-made commode disguised as a chair were a few of the exhibits which created considerable interest among young and old. One lady, expecting her semi-invalid mother to come to live with her, went home and brought her husband to see the equipment so he could copy it. Many comments began, 'If I had only known about this when Joe—or Dad—or Grandma– was sick!'

The spirit of the entire exhibit was happy and cordial but it was felt that the value to our organization was three-fold: Our service was placed before the public, showing how it can and does meet a real need in the community; there was a definite value in stimulating the Auxiliary and lay members of the Board to greater interest in the organization they serve; the nurses themselves, in preparing the practical articles for home use, felt a definite urge toward extending the service."

Wanted: As a contribution from a board member to this Board Members' Page—an appropriate illustration to be used as a department heading. (See the kind and size of illustration used in the School Health, Book Notes, and News departments). Black and white line drawings which, when reduced, will be the right proportion for the headline space will be received with chortles of gratitude since our budget does not permit us to pay for this illustration and the Page very much needs "pointing up" with an attractive decoration. Has your Junior League an "arts and interests" department? Have you talent on your own board or skill at your own fingertips? May we beg you to share it with us?

KATHARINE BIGGS MCKINNEY, *Editor.*

SCHOOL  HEALTH

THE MODERN ELSIE SERIES NO. IV

KEEPING THE WRECK OUT OF RECORDS

It was the last day of the month and Saturday morning. Elsie Carling sat at her desk in the welcome quiet of a school-less day. Only the drone of the janitor's floor polisher sounded in the corridor. In spite of the calm she couldn't seem to add the column of figures that represented the number of children examined during the past month.

"If only I could remember to keep a day-by-day running record of some sort, or if there were only some record form that would summarize everything for me by the month, but here I am with all kinds of services—first aid, health advice, health talks, home visits, teacher conferences, defects corrected—and all I seem to be able to do each day is keep the case history cards up to date, and even those ought to be sorted according to future needs! Besides, I know Dr. Landis is going to ask for a three months' statement for the Board. He said they were questioning the expense of the school health service. I notice *he* never keeps a record—I have to do it all. I've always hated records and I just can't keep them!" And at this point Elsie tossed her pen on the desk in complete despair. She felt ready to cry.

Suddenly her eye caught a motto her mother had sent her to hang over her desk at boarding school. She had always kept it over her various desks as she grew up and it was so familiar now that its message seldom made an impression. It said:

"WHEN YOU DON'T KNOW SOMETHING, KNOW WHERE TO GO TO FIND OUT."

"Um—I wonder. Now if we had a school supervisor in this town I'd go to her, or a state supervising nurse, but I *would* pick a town and state with neither! Maybe the N.O.P.H.N. would help me,* but that will take a week at least. I need help right now on the simplest, most foolproof way to keep records and statistics, the needed ones, not a lot of stuff to check that is never used! I wonder if the man who showed those interesting charts at the last social workers' meeting could help me with some of the elementary things to know about records—I believe I'll call him."

Half an hour later, Miss Carling with all her records for the month was seated at the statistician's desk in the local Family Welfare offices and getting much needed pointers.

She learned for instance:

(1) To carry a continuous summary column like this:

	Vision Tests (to date)
11/20/34	10
11/21/34	13
11/22/34	18

*We would—we will. Let us know your record and statistical problems. Either the statistical department can help you or if the problem is not so much form as content, the N.O.P.H.N. Records Committee or the N.O.P.H.N. School Nursing Section.

the right hand column representing the total tests to date each day, thus giving her a total at the end of each month and year, without further addition. She learned to check groups fast by using the five-unit marking plan: the tally method, of making four vertical lines and a cross line for the fifth unit. She learned to have the child's name on the back as well as the front of the card, to use colored tab signals for different kinds of defects, to keep summary columns always on the extreme right so the eye can run down them easily, to use red ink to record defects corrected, so that they can be spotted at a glance, or to divide the space in half for recording defects, upper half for noting result of examination, lower for corrections; to print all totals in color so they too stand out, to draw up a monthly summary sheet (kept in triplicate—doctor, principal, and files) which included the following items.

a. Readmissions
b. Exclusions
c. Cases of contagion
d. Cultures taken
e. Inspections of pupils
f. First aid
g. Advice and care
h. Conferences with teachers, and parents at school, by phone
i. Sanitary inspections
j. Corrections
k. Talks
l. Meetings attended
m. Time spent in school
n. Time spent in home calls or other business relating to the school health program away from school

To make simple forms, kept in duplicate, for all routine reports (teachers, parents, reminders to children to come to see nurse in her office, etc.), to translate the time spent on various types of activities into percentages and to make simple graphs and "pie charts" showing comparative accomplishments, and she learned that even with the most accurate statistics in the world and the neatest charts, that there are times when only the time-honored case story, told simply and truthfully without dramatics, can really illustrate one's work or demonstrate a need!

From the N.O.P.H.N. she secured the sample record forms for school nursing work, the outline of general factors to consider in planning and using record forms, and some material on how to use records more productively in home visiting.

All of which resulted in a very proud moment for Elsie Carling when, a month later, Dr. Landis burst into her office almost shouting, "Well, the Board is convinced that we are not a luxury, not an unneeded extravagance to be chopped out of the budget for economy's sake! Your statistical report, the graph and the story of Hester Dorland convinced them! Congratulations, Miss Carling, we're here to stay another year!"

HOT LUNCH SCHEMES FOR SCHOOL

Communities have taken up the project of hot school lunches with enthusiasm and resourcefulness. One has provided a mothers' club with a project, and has paid for the food for the family of the mother who prepared the lunch, her husband being out of work. Lunch was brought to school by the high school boys and served by the mother. This initial plan has developed into a barter system. If a family has apples or carrots, beets or potatoes, etc., and cannot afford to pay for the lunch for their child or children, lunch tickets are bartered for their produce, chain store prices being paid.

Massachusetts secured school lunches for children in a very normal, happy way. A mother living next to the school who needed even the slight income which such a project would afford, arranged with the school to supply a noon meal in her home for a very nominal sum. This plan had its advantages in affording a home atmosphere, good hot food and a change from the school rooms. To rural children whose range of social activities is naturally limited, the dining out each day was an occasion.

A similar idea has occurred to a group of young mothers whose children ordinarily return home for the noon meal. At one time this group would have had maids to serve lunch whether the mothers were at home or not. Now the group is almost maidless but days away from home for shopping in the city are as popular as ever. In order to allow this one day off duty, occasionally, it was agreed that one mother in the group of six could be called upon to supply lunch for the children of mothers to be away, at the rate of twenty-five cents a meal.—*Red Cross Courier.*

EDITED BY
DOROTHY J. CARTER

THE ART OF CONFERENCE

By Frank Walser. Harper and Brothers, New York. Price $3.00.

To those who have not been reading the literature on the conference method and working to master its technique during the past decade, Mr. Walser has made a real contribution by drawing together in a very practical and understandable book the best that is known about that art.

To those who have been struggling conscientiously with this procedure during that time, this book brings real refreshment. It serves to revive one's conviction that earnest discussion in which are shared one's deeper convictions on life and its problems is one of the most potent factors in personal and social integration and evolution. Only those who have experienced the growth that such a conference affords can fully appreciate its importance.

Mr. Walser has written this book in a fashion that rings true, for it is out of an unusually rich experience in conducting and observing conferences that he speaks. A chapter on "Planning for the Conference" and another on "Conducting the Conference" are full of concrete suggestions which should serve as a valuable guide to the novice as well as help the more experienced to analyze and correct some of their difficulties. A new emphasis has been placed on the value of silence in the conference and ways of arranging for it have been suggested.

In a chapter on "Personal Integration in Conference," an attempt has been made to analyze the factors within the individual conferee which help him to bring into the discussion a "united front," free from prejudice, earnest in intent, secure with inner satisfaction that makes external applause unnecessary and ready to tackle with some perspective, problems of moment. Although suggestive, in my opinion, this chapter fails to clarify substantially this important factor in conference. Probably rooted deeper than one short book could unravel are indoctrinations in attitudes and methods of thinking, not to be corrected in one generation, but remedied most effectively by the very practice of discussion itself, particularly by young people of today who, as parents of the next generation, will more generally free their children for independent thinking and rational conclusions.

The comprehensive appendix giving a summary of many typical conferences experienced by the author and a splendid bibliography, much of which is annotated, are valuable additions to this book.

LEAH M. BLAISDELL.

SEX-HYGIENE. WHAT TO TEACH AND HOW TO TEACH IT.

By Alfred Worcester, A.M., M.D., Sc. D., Henry K. Oliver, Professor of Hygiene, Harvard University. Springfield, Illinois, Charles C. Thomas, 1934. Price $2.50 postpaid.

Respect for the honored author of this book requires that it be given due consideration. For those who wish to read and think along the more philosophic lines of the subject of sex hygiene, this book will be pleasant reading.

For those, however, who are in the actual press of the necessity of helping young people to solve their problems, we can scarcely recommend it. As one reads the various chapters, he gets the impression that he is living in the nineteenth century rather than the twentieth century. As a matter of fact, the first chapter in the book is a paper which was read in 1899; the second chapter is a paper read in 1913; the third a paper of 1917. All the other chapters

with the exception of the last few were written several years ago. Obviously, things that were true then are still true except for the very different way in which we are looking at things now as compared with then. In a number of places, the author makes a statement that shows that he regards the subject matter as being one that is either unpleasant or very close to becoming unpleasant. This seems a rather strange position for him to take in these modern times. In teaching college freshmen he says that he does not attempt to do anything but answer questions. In such case it is hard to see how he could lead the students into the more wholesome aspects of the subject. It seems to us that sex education needs a far more positive approach than this author has given it.

We can recommend this book only for those who like to regard sex as a subject for philosophic meditation. We certainly cannot recommend it for those who are under the necessity—as who is not?—of regarding sex as the ever-present force which is making and breaking the lives of our young people.

THURMAN B. RICE, M.D.

New reprints from the National Society for Prevention of Blindness, 50 West 50th Street, New York, N. Y.:

Eyesight in Mental and Physical Development. By Arthur P. Wilkinson, M.D. 10c.
The Eyes in Infancy and Childhood. Evelyn L. Coolidge, M.D. 5c.
Conserving the Sight of Myopic Children. Albert Louis Brown, M.D. 5c.
Why Wear Glasses? Philip A. Halper, M.D. 10c.
Home Treatment of the Eyes. William L. Benedict, M.D. 10c.
Contact Glasses. Willis S. Knighton, M.D. 10c.
Program of Eye Health in the School System. Mary Emma Smith, R.N. 10c.
Preventing Blindness Through Social Hygiene Coöperation. Lewis H. Carris. 10c.
Trachoma in the United States. C. E. Rice, M.D. 10c.
Activity Program in Sight-Saving Classes. 5c.

The New York State Department of Health has issued a new health motion picture, "The Tip-Tops in Peppyland." Three clowns demonstrate the value of milk with flashes of actual situations interspersed through the story. Prints in 16 mm. size may be secured for use within the state free of charge. For further information write to the Supervisor of Visual Instruction, State Department of Health, Albany, N. Y.

A study entitled "An Analysis of First Level Public Health Nursing in Ten Selected Health Organizations" by Pearl McIver, R. N., Associate Public Health Nursing Analyst of the United States Public Health Service, has just been prepared in mimeographed form and may be borrowed from the N.O.P.H.N. or purchased for $1.00.

The White Parade is the best moving picture of student nursing we have seen. In spite of the advertised description, "their life of duty begins at six, their love life must end at midnight," the picture is free from undesirable emphases and technically has very few mistakes. The direction is excellent. Nurses, we believe, will enjoy the picture; the general public may be bored.

Miss Grace Abbott has accepted the appointment as Managing Editor of the Social Service Review published by the University of Chicago.

RECENT PAMPHLETS AND ARTICLES

The Incidence of Tuberculous Infection Among Children in New York City. Godias J. Drolet. Reprinted from the American Review of Tuberculosis for July. Available from the Association of Tuberculosis Clinics of Greater New York, 386 Fourth Avenue, New York. Free.

The Welfare of the Teacher. James Frederick Rogers, M.D., U. S. Office of Education. For sale by the Superintendent of Documents, Washington, D. C., 10 cents. A study of present practices in city schools with reference to health examinations of teachers and the granting of leaves for illness and for study and recreation.

The Medical Profession and the Public is the title of the assembled papers read at the joint meeting of the College

of Physicians of Philadelphia and the American Academy of Political and Social Science held in Philadelphia last February. May be purchased from the American Academy of Political and Social Science, Philadelphia, for $1.00.

Notes on Planning a Publicity Program. By Mary Swain Routzahn. The Social Work Publicity Council, 130 East 22d Street, New York, 15 cents.

The Milbank Memorial Fund Quarterly (40 Wall Street, New York City) for October includes the following articles:

Sickness Insurance and Medical Care. Michael M. Davis.
A Cost Analysis of Clearing Tuberculosis Family Contacts. H. R. Edwards, M.D., and Grace Unzicker, R.N.
A Project in Rural School Health Education. Ruth E. Grout.
An Organized Community Health Education Program. Savel Zimand.
Diets of Urban Families with Low Incomes. Dorothy G. Wiehl.

Another periodical worth perusing is the November Journal of Social Hygiene. This is a Health Education number and includes *Venereal Disease and the Patient, The Education of Clinic Patients in Social Hygiene,* and *Notes for a Popular Talk for the General Public on Syphilis and Gonococcal Infections.* This last, by Dr. Walter Clarke, will also be available in reprint form from the American Social Hygiene Association, 50 West 50th Street, for 10 cents.

Parents and Sex Education. Benjamin C. Gruenberg. Revised edition. Published by the Viking Press, New York. May be purchased from the American Social Hygiene Association, 50 West 50th Street, at reduced price of 75 cents.

A bibliography on *Interviewing and Case Recording* may be secured from the Russell Sage Foundation, 130 East 22d Street, New York. 10 cents.

Group Activities for Mentally Retarded Children. Compiled by Elise H. Martens, Office of Education, Washington, D. C. A symposium of activities prepared by teachers of special classes throughout the U.S.A., with illustrations and bibliographies. 149 pages. Order from Superintendent of Documents, Washington, D. C. 15 cents.

A small leaflet, *Syphilis,* gives in brief outline form the pertinent facts a nurse needs to know about the disease. From the A.I.C.P., 105 East 22d Street, New York. 5 cents plus postage.

Heart Disease Among Adolescent School Children of New York City. Morris Goodman, M.D., and Josephine W. Prescott. May be obtained from the Bellevue-Yorkville Health Demonstration, 325 East 38th Street, New York.

Suggestions for Projects in Sight Conservation for Nurses Employed under State or Local Relief Administrations may be obtained from the National Society for the Prevention of Blindness, 50 West 50th Street, New York.

Spending Less for Healthful Food. Prepared by Consumers' Information Service, New York State Department of Agriculture and Markets, Albany, N. Y. Free.

Special Diets at Low Cost. Prepared by Joint Committee, New York Nutritionists and Greater New York Dietetic Association and approved by Committee on Public Health Relations, New York Academy of Medicine. 25 cents from Jewish Social Service Association, 67 West 47th Street, New York.

FROM CURRENT PERIODICALS

The rôle of the woman school physician. Very Heinly Jones, M.D. Medical Woman's Journal, November, 1934.

Poisoning in industry. Annette Fiske. Hygeia, November, 1934. The need of a physician and nurse to care for the health of workers in factories where hazardous work is done is especially great.

Mental hygiene opportunities of primary teachers. Esther Loring Richards, M.D. Child Health Bulletin, November, 1934.

The mental hygiene of pregnancy. Glee L. Hastings. Trained Nurse and Hospital Review, October, 1934.

Five-cent dishes feature quality, quantity, and appearance. Clarence B. Kugler, Jr. The Nation's Schools, October, 1934.

The myth of the average child. I. Newton Kugelmass. Hygeia, 1934.

San Diego central clinic service. Journal of the American Medical Association, September 22, 1934. A description of the organization and functioning of the service.

Carbon tetrachloride as an industrial hazard. Paul A. Davis, M.D. Journal of American Medical Association, September 29, 1934.

Dental defects and mental hygiene—a radio talk. Kermit F. Knudtzon, D.D.S. Mental Health Bulletin (Illinois Society for Mental Hygiene, Chicago), October, 1934.

Wasn't that a good speech! A code for convention speakers. Max J. Herzberg. Journal of the National Education Association, November, 1934.

Something can be done about the common cold. Paul A. Campbell, M.D. The Nation's Schools, November, 1934. How Culver Military Academy reduced its incidence of colds 26 per cent.

American education and the Negro. James A. Scott. School and Society, November 10, 1934.

Heart disease—how to avoid it—how to live with it. Mouth Health Quarterly, July-September, 1934. With bibliography.

The effect of improved diet on children with a moderate degree of hookworm infection. Ouida Davis Abbott. Journal of Home Economics, November, 1934.

Practical application of school health principles. Harold H. Mitchell, M.D. American Journal of Public Health, November, 1934.

New frontiers in public health nursing. Sybil H. Pease. The Canadian Nurse, November, 1934.

Eliminating sandwiches from the school lunch. Nation's Schools, Chicago, November, 1934.

Following are some of the recent publications from the Bureau of Publications, Teachers College, Columbia University, New York:

Resistant Behavior of Preschool Children. By Ruth Kennedy. Faille. $1.50.

The Developmental Status of the Preschool Child as a Prognosis of Future Development. By Gertrude Porter Driscoll. $1.50.

Children's Fears, Dreams, Wishes, Daydreams, Likes, Dislikes, Pleasant and Unpleasant Memories: A study by the interview method of 400 children aged 5 to 12. By Arthur I. Jersild, Frances V. Markay, and Catharine L. Jersild. $1.75.

Health Education for Teachers: A critical study of the pre-service preparation of classroom teachers for the school health program. By Mary Elisabeth Spencer. $1.50.

BIBLIOGRAPHY ON HEALTH INSURANCE

American Academy of Political and Social Science, *The Medical Profession and the Public,* Philadelphia, 1934, 112 pp.

American Medical Association Bulletin, "A Critical Analysis of Sickness Insurance," Vol. 29, No. 4, April, 1934, pp. 49-80.

British Medical Journal, Supplement, July 7, 1934, "The Scottish Health Services." 17 pp.

British Medical Association, *Proposals for a General Medical Service for the Nation,* 1930. 48 pp. 6d.

Canada, British Columbia, Royal Commission on State Health Insurance and Maternity Benefits, Final Report, 1932. 63 pp.

Commission on Medical Education, Final Report, New York, Columbia University Press, 1932. 560 pp. $2.00.

Committee on Costs of Medical Care, *Medical Care for the American People.* Final Report of the Committee, Chicago, University of Chicago Press, 1932. 213 pp. $1.50. Falk, I. S., Rorem, C. R., and Ring, M. D., *The Costs of Medical Care,* 1933. 625 pp. $4.00. Falk, I. S., Klem, Margaret C., and Sinai, Nathan, *The Incidence of Illness and the Receipts and Costs of Medical Care among Representative Family Groups,* 1933. 327 pp. $3.00. Lee, R. I., and Jones, L. W., *Fundamentals of Good Medical Care,* 1933. 302 pp. $2.50. Reed, L. S., *The Ability to Pay for Medical Care,* Chicago, University of Chicago Press, 1933. 113 pp. $2.00.

Fishbein, Morris, *Sickness Insurance and Sickness Costs, Hygeia,* December, 1934.

McCleary, G. F., *National Health Insurance,* London, Lewis, 1932. 185 pp. 6s.

Metropolitan Life Insurance Company, Monograph 5: *Health Insurance, A Summary of Some Existing Plans to Provide Maintenance and Medical Care for the Sick,* 1933. 40 pp. Free.

Newsholme, Sir Arthur, *International Studies on the Relation between Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease.* Vols. 1-3, pp. 248; 249, 558. Baltimore, Williams and Wilkins, 1931. Vols. 1-2, each $4.00; Vol. 3, $5.00. *Medicine and the State,* Baltimore, Williams and Wilkins, 1932. 300 pp. $3.50.

Simons, A. M., and Sinai, Nathan, *The Way of Health Insurance,* Chicago, University of Chicago Press, 1932. 215 pp. $2.00.

Survey Graphic, December, 1934, *Buying Health.*

Williams, Pierce, *The Purchase of Medical Care Through Fixed Periodic Payment,* N. Y., National Bureau of Economic Research, 1932. 320 pp. $3.00.

Great encouragement for the development of public health programs in the rural areas of the United States is shown through the recent announcement that $1,000,000 has been allotted to the U. S. Public Health Service from F.E.R.A. funds for the establishment or maintenance of permanent local health services in rural areas. Where state or local funds are insufficient to provide for adequate health service, financial aid will be given by the Public Health Service through state health departments to assist

(1) In the maintenance of existing full-time county health units
(2) In the establishment of new full-time county or district health units
(3) In the establishment of facilities in the state health department for adequate promotion and supervision of county health service.

It is planned to use only qualified personnel in the establishment of new services.

✣

Katharine Lenroot has been appointed Chief of the U. S. Children's Bureau, Department of Labor, to succeed Grace Abbott.

✣

Katharine Tucker, General Director of the N.O.P.H.N., has been invited to serve on the Public Health Advisory Committee to the President's Committee on Economic Security. One meeting of this committee has been held in Washington.

✣

Anita Jones of the Maternity Center Association, New York City, has been lent to the U. S. Children's Bureau for three months to give institutes on maternal and child health to nurses in several western states.

The American Child Health Association will hold its eighth Health Education Conference in Iowa City, June 19 through June 22, 1935, at the invitation of the University of Iowa. The conference will be held in conjunction with the ninth annual Iowa Conference on Child Development and Parent Education, which is scheduled for June 17 to 19 inclusive.

✣

Word comes from the International Council of Nurses in Geneva that with the issue of Volume IX of *The International Nursing Review*, dated 1934, further publication of that *Review* has been indefinitely suspended, pending the decision by the Board of Directors as to the further policy they propose to adopt with reference to the same. The question will come before the Board at their next meeting in 1935. Subscriptions which have been received in advance will be held in suspense until the Board have arrived at a decision with regard to the future of this publication.

✣

The Kings County Medical Society of Brooklyn, N. Y., has embarked on a program to reduce maternal mortality in Brooklyn, and has appointed a special committee for an extensive educational program to reach the medical profession, hospitals, the public, and midwives. Dr. Charles A. Gordon is chairman of this committee.

✣

The new officers for 1935 of the New York Industrial Nurses' Club are:

President—Mrs. Elisabeth H. Emery
Vice-President—Mabel A. Husing
Treasurer—Edith F. Ryder
Secretary—Adelaide Matthews.

The Club is sponsoring a course of eight lectures in Mental Hygiene to be

presented by Dr. George K. Pratt, starting January 7, bi-weekly in the evenings. Graduate nurses interested may secure further information from Belle Carver, Brooklyn Union Gas Company, East 83d Street and Ditmas Avenue, Brooklyn, N. Y.

The January meeting of the Club will be held January 10, at the Central Club for Nurses, 132 East 45th Street, New York City, at 8 P.M., speaker Dr. Margaret Witter Barnard, Department of Health, New York City, and on February 14, at the same time and place, Hon. Elmer F. Andrews, Industrial Commissioner, New York State Department of Labor, will address the Club.

✣

The fourth annual meeting of the Massachusetts Organization for Public Health Nursing was held Friday, November 2, at the Hotel Statler, Boston.

A one-act play, "When Board Members Meet," was staged and acted by board members and nurses.

At the luncheon meeting Effie J. Taylor, Dean of the Yale School of Nursing, spoke on "Trends in Nursing Education."

Alma C. Haupt, Associate Director of the N.O.P.H.N., spoke on "Recent Adjustments in Public Health Nursing Services" at the board members' meeting and Sophie C. Nelson conducted a symposium on the "Survey of Public Health Nursing" for public health nurses.

The School Nurses' Section also met at which Miss Haupt presented a discussion on the Survey as it relates to school nursing.

✣

The fall meeting of the Connecticut Board Members' Organization was held in Torrington, October 24th, 1934. The president, Mrs. Clarence L. Clark, of New Haven, presided and over one hundred delegates came from associations all over the State.

One of the high spots in the day's program was a demonstration of a model board meeting. The reports given by the chairmen at this model meeting were in some cases actual reports, and in others composite pictures, of business carried on by visiting nurse associations in Connecticut. The senior nurse of this model two-nurse association was present throughout the board meeting. The advisability of printed annual reports, the increased use of volunteers, the careful choice of new board members, the need of board members to inform themselves as to their duties by reading Mrs. Hammer's article, "I Look at Myself; What Do I Find?"* were some of the important facts brought out at this model board meeting.

The afternoon was given over to a group of four round tables for discussion of problems which confront visiting nurse associations.

✣

An institute for school nurses held under the auspices of the School Nurses' Section of the New Jersey S.O.P.H.N., was held in Atlantic City, November 10. Dorothy J. Carter of the N.O.P.H.N. staff conducted the institute.

On November 17 in New Haven, Connecticut, an institute for school nurses was held, sponsored by the New Haven Board of Education. Miss Carter also conducted this institute.

✣

New Yorkers had the pleasure in December of hearing Dr. Allan Roy Dafoe of quintuplet fame discuss the advent and subsequent handling of the Canadian babies. Dr. Dafoe paid this tribute to the nurses:

> We have been particularly fortunate in having such splendid nurses. They have been intelligent, vigilant and most faithful in their duty. Every one knows, I am sure, the value of good nursing with any case, but this is particularly true in the care of premature infants. A great deal of credit should go to them for the survival of these babies.

✣

As we go to press the morning papers carry the news of the death of Dr. Theobald Smith, noted pathologist, to whom public health workers owe so much for his discoveries among insect-borne diseases, bovine tuberculosis, and immunology.

*See the September, 1934, number of PUBLIC HEALTH NURSING.

Official Directory of Public Health Nurses

Listing those holding executive positions in the Government and in states, and officers of state organizations for public health nursing and public health nursing sections of state nurses' associations.

Information as of December 1, 1934, unless otherwise stated

The National Organization for Public Health Nursing, Inc.

President, Amelia Grant, Department of Health, New York, N. Y. Director, Katharine Tucker, 50 West 50th St., New York, N. Y.

American Red Cross, Nursing Service

National Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Public Health Nursing and Home Hygiene Service

National Director, I. Malinde Havey, American Red Cross, Washington, D. C.

Eastern Area: Assistant Directors, Annabelle Petersen, Helen Dunn, Mrs. Charlotte Heilman, Mary DeLaskey, Margaret Dizney, Marie Peterson, American Red Cross, Washington, D. C.

Midwestern Area: Director, Mrs. Elsbeth Vaughan. Assistant Directors, Lona Trott, Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

Pacific Area: Director, Rena Haig, Civic Auditorium, San Francisco, Cal.

U. S. Army Nurse Corps

Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

U. S. Navy Nurse Corps

Superintendent, J. Beatrice Bowman, 1314 Navy Department, Washington, D. C.

U. S. Public Health Service

Lucy Minnigerode, Supt. Nurse Corps, Office of the Surgeon General, Washington, D. C.

Pearl McIver, Associate Public Health Nursing Analyst, Treasury Department, Washington, D. C.

U. S. Veterans' Bureau Nursing Service

Superintendent, Mrs. Mary A. Hickey, Veterans' Administration, Washington, D. C.

Indian Bureau

Supervisor of Nurses, Elinor D. Gregg, U. S. Department of the Interior, Office of Indian Affairs, Washington, D. C.

ALABAMA

State Board of Health, Department of Public Health—Adviser, Frances Montgomery, Montgomery

State Nurses' Association Paid Executive—Ann Beddow, Norwood Hospital, 1601 N. 25th St., Birmingham.

American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

ARIZONA

American Red Cross Nursing Field Representative—Calista Crown, American Red Cross, Civic Auditorium, San Francisco, Cal.

ARKANSAS

State Organization for Public Health Nursing—Pres., Mary Rignier, Hamburg. Sec., Leona Hass, Ashdown. Treas., Ruby Odenbaugh, Lewisville.

State Board of Health—Supervisor of Public Health Nurses, Eupha Hixson, Little Rock.

Arkansas Tuberculosis Association—Mrs. Virginia Troupe, Pine Bluff.

American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

CALIFORNIA

State Organization for Public Health Nursing—Pres., Naomi Deutsch, 2683 Le Conte, Berkeley. Sec., Rena Haig, Civic Auditorium, San Francisco. Treas., Janet M. Roush, 726 S. Tuxedo, Stockton.

California Tuberculosis Association, 582 Market St., San Francisco—Irene E. Carlson, 33 Loyola Terrace, San Francisco. Beatrice H. Woodward, c/o Y.W.C.A., 650 Sutter St., San Francisco.

State Nurses Association Paid Executive—Anna C. Jammé, Room 502, 609 Sutter St., San Francisco.

American Red Cross Nursing Field Representative—Calista Crown, Civic Auditorium, San Francisco.

COLORADO

Section on Public Health Nursing of State Nurses' Association—Chairman, Genevieve Artz, Visiting Nurse Association, 314 14th St., Denver. Vice-Chairman, Alicia Kops, 1914 Elizabeth, Pueblo. Sec., Ruth Blackburn Huddleston, 1589 Jackson St., Denver.

Colorado Tuberculosis Association—Ruth E. Phillips, 305 Barth Building, Denver.

State Nurses' Association Paid Executive—Irene Murchison, 302 Capitol Bldg., Denver.

American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Avenue, St. Louis, Mo.

CONNECTICUT

Section on Public Health Nursing of State Nurses' Association—Chairman, Irma E. Reeve, Visiting Nurse Association, 35 Elm St., New Haven. Vice-Chairman, Mary Maher, United Workers of Norwich, Norwich.

State Department of Health, Bureau of Public Health Nursing—Elizabeth S. Taylor, Director, Station A. Box K, Hartford.

State Nurses' Association Paid Executive—Margaret K. Stack, 175 Broad St., Hartford.

American Red Cross Nursing Field Representative—Elizabeth S. Taylor, American Red Cross, Washington, D. C.

DELAWARE

Section on Public Health Nursing of State Nurses' Association—Chairman, Lora J. Thompson, 1531 Delaware Ave., Wilmington. Vice-Chairman, Helen Dill, 303 Rodman Road, Gordon Heights. Sec., Mary Morris, 3 Elmhurst Place, Richardson Park.

DISTRICT OF COLUMBIA

Section on Public Health Nursing of District Graduate Nurses' Association—Chairman, Mary C. Connor, 2308 Ashmead Pl., N. W. Vice-Chairman, Edith B. Aldridge, 819 Allison St., N. W. Sec., Charlotte Hasselbusch, 637 Ingraham St., N. W.

District Health Department, Child Hygiene Service—Edith B. Aldridge, Chief Nurse, Room 203 District Bldg., Washington, D. C.

District Nurses' Association Paid Executive—Sena Anderson, 60-1746 K St., N. W.

FLORIDA

Section on Public Health Nursing of State Nurses' Association—Chairman, Gwendoline Jones, Box 548, Daytona Beach. Vice-Chairman, Lalla M. Goggins, Marianna. Sec., Miss Rogers, Daytona Beach.

State Board of Health, Division of Public Health Nursing—Ruth E. Mettinger, Director, 2d and Julia Sts., Jacksonville.

American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

GEORGIA

State Organization for Public Health Nursing—Pres., Evelyn Dugger, 133 10th St., N. E., Atlanta. Sec., Elmina Austin, 1031 Ponce De Leon Ave., N. E., Atlanta. Treas., Ruth Smith, Health Dept., Macon.

State Department of Health—Mrs. Abbie R. Weaver, Supervisor of Nursing Projects, State Capitol, Atlanta.

State Nurses' Association Paid Executive—Jean Harrell, 131 Forrest Ave., N. E., Atlanta.

American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

IDAHO

Idaho Anti-Tuberculosis Association—Margaret Thomas, Box 1703, Boise.

American Red Cross Nursing Field Representative—Calista Crown, American Red Cross, Civic Auditorium, San Francisco.

ILLINOIS

Section on Public Health Nursing of State Nurses' Association—Chairman, Sarah E. Daily, 820 E. Converse St., Springfield. Sec., Alma Keyl, Decatur.

State Board of Health—Leone W. Ware, Acting Supervising Nurse, Capitol Bldg., Springfield.

State Nurses' Association Paid Executive—Ada Reitz Crocker, 8 S. Michigan Ave., Chicago.

American Red Cross Nursing Field Representative—Rebecca Pond, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

INDIANA

Section on Public Health Nursing of State Nurses' Association—Chairman, Beatrice Short, 808 Majestic Bldg., Indianapolis. Vice-Chairman, Matilda Lebline, Seymour. Sec., Genevieve Shaw, 1610 High St., Logansport.

State Board of Health, Division of Public Health Nursing—Director, Eva F. MacDougall, 6 State House Annex, Indianapolis.

State Nurses' Association Paid Executive—Helen Teal, 1227 Circle Tower, Indianapolis.

American Red Cross Nursing Field Representative—Irma Fortune, American Red Cross, Washington, D. C.

IOWA

Section on Public Health Nursing of State Nurses' Association—Chairman, Bertha Harvey, 1202 W. 3d St., Davenport. Vice-Chairman, Mrs. Lucy Deppert, Iowa State Tuberculosis Association, Des Moines. Sec., Edith Holmstrom, Extension Division, University of Iowa, Dental Building, Iowa City.

State Department of Health, Public Health Nursing—Edith S. Countryman, Director, Des Moines.

Iowa Tuberculosis Association, 610 Flynn Bldg., Des Moines—Field Nurse, Marguerite Pfeffer.

American Red Cross Nursing Field Representative—Nora Rolf, American Red Cross, 1709 Washington Ave., St. Louis, Missouri.

KANSAS

Section on Public Health Nursing of State Nurses' Association—Pres., Mary McAuliffe, State Board of Health, Topeka. Sec., Nellie Jewell, County Health Unit, Wichita. Publicity Chairman, Grace Moore, 806 W. 11th St., Wichita.

State Board of Health—Mary E. McAuliffe, Public Health Nurse, Topeka.

Kansas Tuberculosis and Health Association—Velma G. Long, 824 Kansas Ave., Topeka.

American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis.

KENTUCKY

State Organization for Public Health Nursing—Pres., Bettie McDanald, 215 E. Walnut St., Louisville. Sec., Kittie Baird, Versailles. Treas., Charlotte Pitman, 215 E. Walnut St., Louisville.

State Dept. of Health, Bureau of Public Health Nursing—Margaret L. East, Director, 532 W. Main St., Louisville.

Kentucky Tuberculosis Association, 532 W. Main, Louisville—Margaret L. East, Supervising Nurse.

State Nurses' Association Paid Executive—Elsie Pearson, 1005 S. Floyd St., Louisville.

American Red Cross Nursing Field Representative—Irma Fortune, American Red Cross, Washington, D. C.

LOUISIANA

Section on Public Health Nursing of State Nurses' Association—Laurence Bernard, Caddo Parish Health Unit, Shreveport.

State Board of Health, Bureau of Parish Health Administration—Emma Maurin, Field Nurse Adviser, 223 Court House, New Orleans.

American Red Cross Nursing Field Representative—Irma Fortune, American Red Cross, Washington, D. C.

MAINE

Section on Public Health Nursing of State Nurses' Association—Chairman, Ethel MacLean, American Red Cross, So. Portland. Vice-Chairman, Juliette Giguere, Board of Health, Lewiston. Sec.-Treas., Mrs. Louise Nichols, Dover Foxcroft.

State Department of Health, Division of Public Health Nursing and Child Hygiene—Edith Soule, Director, State House, Augusta.

Maine Public Health Association—Theresa R. Anderson, 256 Water St., Augusta.

American Red Cross Nursing Field Representative—Laura Knowlton, American Red Cross, Washington, D. C.

MARYLAND

State Organization for Public Health Nursing—Pres., Marcie Wheat, Baltimore Milk Fund Association, 31 S. Calvert St., Baltimore. Sec., Mary H. Williams, Baltimore Milk Fund Association. Treas., Grace Volmar, Health Dept., Municipal Bldg., Baltimore.

American Red Cross Nursing Field Representative—Marie Peterson, American Red Cross, Washington, D. C.

State Nurses' Association Paid Executive—Mrs. Blanche Powell, 1211 Cathedral St., Baltimore.

MASSACHUSETTS

Organization for Public Health Nursing (not a branch of N.O.P.H.N.)—Pres., Mrs. Harold Marvin, 22 Edgehill Road, Chestnut Hill. Sec., Mrs. F. L. Dellenbaugh, Spooner Road, Brookline. Treas., Hilga Nelson, Visiting Nurse Association, Newtonville.

State Department of Public Health, Department of Public Health Nursing—Ada Boone Coffey, Chief Consultant, 545 State House, Boston (on leave of absence).

State Nurses' Association Paid Executive—Helene G. Lee, 420 Boylston Street, Boston.

American Red Cross Nursing Field Representative—Anna Gring, American Red Cross, Washington, D. C.

MICHIGAN

State Organization for Public Health Nursing (not a branch of N.O.P.H.N.)—Pres., Milenka Herc, 659 Webb, Detroit. Sec., Hazel Herringshaw, Box 63, Calumet. Treas., Bosse B. Randle, City Hall, Grand Rapids.

State Department of Health, Bureau of Child Hygiene and Public Health Nursing—Mrs. Helen DeSpelder Moore, Assistant Director, Lansing.
State Nurses' Association Paid Executive—Olive Sewell, Capitol Savings and Loan Bank Bldg., Lansing.
American Red Cross Nursing Field Representative—Rebecca Pond, 1709 Washington Ave., St. Louis, Mo.

MINNESOTA

State Organization for Public Health Nursing—Pres., Agnes Leahy, Metropolitan Life Insurance Service, 89 East 5th, St. Paul. Sec., Helen Hestad, 404 So. 8th St., Room 244, Minneapolis. Treas., Ann Nyquist, Division of Child Hygiene, University of Minnesota, Minneapolis.
State Department of Health, Division of Child Hygiene—Olivia T. Peterson, Superintendent, University Campus, Minneapolis.
State Nurses' Association Paid Executive—Caroline Rankiellour, 2642 University Ave., St. Paul.
American Red Cross Nursing Field Representative—Rebecca Pond, 1709 Washington Ave., St. Louis, Mo.

MISSISSIPPI

Section on Public Health Nursing of State Nurses' Association—Chairman, Pattie R. Sanders, Rosedale.
State Board of Health, Child Hygiene and Public Health Nursing—Mary D. Osborne, Associate Director, Jackson.
American Red Cross Nursing Field Representative—Irma Fortune, American Red Cross, Washington, D. C.

MISSOURI

Section on Public Health Nursing of State Nurses' Association—Chairman, Audrey Holt, Visiting Nurse Association, Kansas City. Vice-Chairman, Hetty Joach, County Court House, Jefferson City. Sec., Esther Cloud, Metropolitan Life Insurance Company, Joplin.
State Board of Health, Public Health Nursing—Helen A. Dunham, Director, State Capitol Building, Jefferson City.
Missouri Tuberculosis Association—Helen A. Dunham, State Capitol Bldg., Jefferson City.
State Nurses' Association Paid Executive—Elizabeth Martin, 1021 E. Lynwood Blvd., Kansas City.
American Red Cross Nursing Field Representative—Nora Rolf, American Red Cross, 1709 Washington Ave., St. Louis.

MONTANA

State Nurses' Association Paid Executive—Edith L. Brown, Box 928, Helena.
American Red Cross Nursing Field Representative—Nora Rolf, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

NEBRASKA

Section on Public Health Nursing of State Nurses' Association—Chairman, Elsie Hampel, 524 Park Ave., Omaha. Vice-Chairman, Eva Wichmann, 2702 Burt St., Omaha. Sec., Hazel Tublos, 1630 H St., Apt. c 3, Lincoln.
American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

NEVADA

Nevada Public Health Association (Tuberculosis)—Christie Thompson, Supt. of Nurses, Reno.

NEW HAMPSHIRE

Section on Public Health Nursing of State Nurses' Association—Chairman, Ruth Whitcomb, 97 No. State St., Concord. Vice-Chairman, Margarite Cronin, 424 Cedar St., Manchester. Sec. and Treas., Agnes E. Doherty, 336 Notre Dame Ave., Manchester.
State Department of Health, Division of Maternity, Infancy, and Child Hygiene—Mrs. Mary D. Davis, Director, State House, Concord.
State Board of Education—School Supervisor of Health, Elizabeth M. Murphy, Patriot Bldg., Concord.
American Red Cross Nursing Field Representative—Laura Knowlton, American Red Cross, Washington, D. C.

NEW JERSEY

State Organization for Public Health Nursing—Pres., Hettie Seifert, 1301 Union Co. Court House, Elizabeth. Sec., Marian E. Lockwood, 574 Rahway Ave., Woodbridge. Treas., Mrs. Ann Munn Pomeroy, 99 Valley Rd., Montclair.
State Department of Health—Bureau of Child Hygiene—Alice F. Boyer, Supervisor of Nurses, Trenton.
State Department of Public Instruction, Assistant in Health Education—Lulu P. Dilworth, 1208 Trenton Trust Company Bldg., Trenton.
State Nurses' Association Paid Executive—Arabella Creech, 17 Academy St., Newark.
American Red Cross Nursing Field Representative—Gladyce Badger, American Red Cross, Washington, D. C.

NEW MEXICO

Section on Public Health Nursing of State Nurses' Association—Chairman, Ruth Ryden, Carrizozo. Vice-Chairman, Ada Levy, Los Lumas. Sec., Eleanor Kennedy, Santa Fe.
State Department of Health, Bureau of Public Health—Grace M. Coffman, Supervisor, Box 711, Santa Fe.
New Mexico Tuberculosis Association—Mrs. V. E. Berchtold, Executive Secretary, St. Vincent's Sanatorium, Santa Fe.
American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

NEW YORK

State Organization for Public Health Nursing—Pres., Geneva F. Hoilien, Albany Guild for Public Health Nursing, 245 Lark St., Albany. Sec., Mrs. Grace M. D. MacLaren, 14 Glenwolde, Tarrytown. Treas., Bertice A. Rees, 65 Court St., Buffalo.
State Department of Health, Division of Public Health Nursing—Marion W. Sheahan, Director, State Education Building, Albany.
State Department of Education—Supervisors of School Nurses, Anna M. Neukon and Marie E. Swanson, State Education Bldg., Albany.
State Nurses' Association Paid Executive—Emily J. Hicks, 103 Washington Ave., Albany.
American Red Cross Nursing Field Representative—Gladyce Badger, American Red Cross, Washington, D. C.

NORTH CAROLINA

Section on Public Health Nursing of State Nurses' Association—Chairman, Columbia Munds, Dept. of Health, Wilmington. Vice-Chairman, Amoret Davis, Fayetteville. Sec., Betty Henry, Dept. of Health, Charlotte.
American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

NORTH DAKOTA

Public Health Nursing Section of State Nurses' Association—Pres., Ruth Wisnaes, City Health Dept., Bismarck. Vice-Pres., Mrs. Gene Johnson James, Box 265, Page.
State Board of Health—Ruth I. Wisnaes, State Supervisor, F.E.R.A. Nursing Program, Bismarck.
American Red Cross Nursing Field Representative—Rebecca Pond, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

OHIO

Section on Public Health Nursing of State Nurses' Association—Chairman, Cora M. Templeton, Room 117, City Hall, Cleveland. Vice-Chairman, Loneta Campbell, Cincinnati. Sec., Nelle Martin, 764 Miller Ave., Columbus.

State Nurses' Association Paid Executive—Mrs. E. P. August, 50 E. Broad St., Columbus.
American Red Cross Nursing Field Representative—Miriam Dailey, American Red Cross, Washington, D. C.

OKLAHOMA

State Organization for Public Health Nursing—Pres., Lucile Loveless, Route 7, Oklahoma City. Sec., Eleanore Moore, 505 Ramsey Tower, Oklahoma City. Treas., Kittie Miser, 1124 So. Florence Ave., Tulsa.
American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

OREGON

State Organization for Public Health Nursing—Pres., Mrs. Linnie Laird, 2315 N. E. 43d Ave., Portland. Sec., Louise Thielen, 1109 S. E. 72d Ave., Portland. Treas. Josephine Brooks, 2146 N. W. Marshall St., Portland.
State Board of Health, Division of Public Health Nursing and Child Hygiene—Mary P. Billmeyer, State Advisory Nurse, 816 Oregon Bldg., Portland.
State Nurses' Association Paid Executive—Jane Gavin, 305 Stevens Bldg., Portland.
Oregon Tuberculosis Association—Field Nurses, L. Grace Holmes, Margaret Gillis, Edna Flanagan, 605 Woodlark Bldg., Portland.
American Red Cross Nursing Field Representative—Calista Crown, Civic Auditorium, San Francisco.

PENNSYLVANIA

State Organization for Public Health Nursing—Pres., Fannie Eshleman, Phipps Institute, 7th and Lombard Sts., Philadelphia. Sec., Kathryn D. Gibson, Visiting Nurse Association, Scranton. Treas., Elizabeth Scarborough, 1340 Lombard St., Philadelphia.
State Department of Health, Bureau of Public Health Nursing—Mrs. Mary S. Evans, Director, Harrisburg.
State Department of Public Instruction—Mrs. Lois Owen, School Nursing Advisor, Harrisburg.
Pennsylvania Tuberculosis Society, 311 S. Juniper St.—Frances H. Meyer, Philadelphia.
State Nurses' Association Paid Executive—Esther R. Entriken, 400 N. 3d St., Harrisburg.

RHODE ISLAND

State Organization for Public Health Nursing—Pres., Helen J. Marble, 204 High St., Pawtucket. Sec., Ruth Anderson, 30 Rolfe St., Cranston. Treas., Katherine Murphy, 110 High St., Pawtucket.
State Nurses' Association Paid Executive—Annie M. Earley, 381 Angell St., Providence.
American Red Cross Nursing Field Representative—Anna Gring, American Red Cross, Washington, D. C.

SOUTH CAROLINA

Committee on Public Health of State Nurses' Association—Chairman, Antonia B. Gibson, 7 Ann Park, Sumter. Sec., Margaret Brinkman, County Health Department, Spartanburg. Treas., Jennie McMaster, 1218 Senate St., Columbia.
American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

SOUTH DAKOTA

Section on Public Health Nursing of State Nurses' Association—Chairman, Vera Halver, Sioux Falls. Vice-Chairman, Ruth Levallium, Sioux Falls. Sec., Nell Helett, Mitchell.
State Board of Health—Mrs. Florence W. Englesby, State Supervisor of Child Health Nursing Project under the F.E.R.A., 800 Capitol Ave., Pierre.
South Dakota Public Health Association (Tuberculosis)—Mrs. Florence W. Englesby, State Supervisor of C.W.A. Nursing Project, Pierre.
American Red Cross Nursing Field Representative—Nora Rolf, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

TENNESSEE

Section on Public Health Nursing of State Nurses' Association—Chairman, Mary J. Dunn, School of Nursing, Vanderbilt University, Nashville.
State Department of Health, Public Health Nursing—Donna Pearce, Associate, War Memorial Building, Nashville.
American Red Cross Nursing Field Representative—Irma Fortune, American Red Cross, Washington, D. C.

TEXAS

State Organization for Public Health Nursing—Pres., Elizabeth Shellabarger, Y.M.C.A., El Paso. Sec. and Treas., Celia Moore, State Dept. of Health, Austin.
State Nurses' Association Paid Executive—A. Louise Dietrich, 1001 E. Nevada St., El Paso.
American Red Cross Nursing Field Representative—Ella Gimmestad, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

UTAH

State Organization for Public Health Nursing—Pres., Louise Van Ee, 114 Canyon Rd., Salt Lake City. Sec., Anna Fillmore, State Capitol, Salt Lake City. Treas., Mrs. Afton Wirick, 530 E. 1st South, Salt Lake City.
State Board of Health—Anna Fillmore, State Advisory Nurse, E.R.A., Salt Lake City.
Utah Tuberculosis Association—Ada Taylor Graham, Executive Secretary, No. 44, 930 E. 3d So., Salt Lake City.
American Red Cross Nursing Field Representative—Calista Crown, Civic Auditorium, San Francisco.

VERMONT

Section on Public Health Nursing of State Nurses' Association—Chairman, Evelyn Coleman, Supervisor Visiting Nurse Association, Burlington. Sec. and Treas., Helen L. Pease, Main St., Waterbury. Vice-Chairman, Lucy Walsh, Rutland.
State Board of Health—Nellie M. Jones, Director Maternity and Infancy Division, Brandon.
Vermont Tuberculosis Association—Mrs. Helena P. Lindsay, Upper Terrace, Montpelier; Constance E. Galaise, 8 Greene St., Burlington.
American Red Cross Nursing Field Representative—Laura Knowlton, American Red Cross, Washington, D. C.

VIRGINIA

Section on Public Health Nursing of State Nurses' Association—Chairman, Mrs. Fereba B. Croxton, Hanover. Sec., Mamie Rice, Farmville.
State Board of Health, Bureau of Public Health Nursing—Mary I. Mastin, Director, State Office Building, Richmond.
State Nurses' Association Paid Executive—Mrs. Jessie W. Faris, 3015 E. Broad St., Richmond.
American Red Cross Nursing Field Representative—Miriam Dailey, American Red Cross, Washington, D. C.

WASHINGTON

State Organization for Public Health Nursing—Pres., Minerva Blegen, Spokane Co. Court House, Spokane. Sec., W. A. Robinson, 809 West 4th, Spokane. Treas., Anna Carlson, Court House, Mt. Vernon.
State Department of Health, Public Health Nursing—Mrs. Mary Louise Allen, State Advisory Nurse, 1504 Alaska Bldg., Seattle.
State Nurses' Association Paid Executive—Cora Gillespie, 327 Cobb Bldg., Seattle.
American Red Cross Nursing Field Representative—Calista Crown, American Red Cross, Civic Auditorium, San Francisco.

WEST VIRGINIA

Section on Public Health Nursing of State Nurses' Association—Chairman, Lottie Mathison, 1034 8th St., Huntington. Vice-Chairman, Sara Hall, Health and Nutrition Project, City Bldg., Morgantown. Sec., Cecilia Robrecht, R. D. No. 1, Triadelphia.

State Department of Health—Mrs. Mary Keith Cauthorne, State Advisory Nurse, Charleston.

American Red Cross Nursing Field Representative—Miriam Dailey, American Red Cross, Washington, D. C.

WISCONSIN

Section on Public Health Nursing of State Nurses' Association—Chairman, Edith Olson, 22 N. Hancock St., Madison. Sec., Cecilia Geising, Court House, Wausau.

State Board of Health, Public Health Nursing—Cornelia van Kooy, Supervisor, State Capitol, Madison.

Wisconsin Anti-Tuberculosis Association—Doris Kerwin, 1018 N. Jefferson St., Milwaukee.

American Red Cross Nursing Field Representative—Rebecca Pond, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

WYOMING

Organization for Public Health Nursing (not a branch of N.O.P.H.N.)—Pres., Mrs. M. M. LeBlanc, Administration Bldg., Cheyenne. Vice-Pres., Valerie Rittenhouse, University of Wyoming, Laramie. Sec. and Treas., Mrs. Georgia Zipfel, Capitol Bldg., Cheyenne.

State Board of Health—Mrs. Georgia Zipfel, State Nurse, Capitol Bldg., Cheyenne.

American Red Cross Nursing Field Representative—Nora Rolf, American Red Cross, 1709 Washington Ave., St. Louis, Mo.

TERRITORIAL POSSESSIONS

HAWAII

Territorial Board of Health, Bureau of Public Health Nursing—Mabel L. Smyth, Director, Honolulu.

Nursing Department, Palama Settlement—Amy MacOwen, Director, Honolulu.

PANAMA CANAL

City of Panama, Visiting Nurse Service—Synneve Y. Eikum, Supervising Nurse, care of Health Officer, Panama, Ancon, C. Z.

PHILIPPINE ISLANDS

Filipino Nurses' Association—Pres., Rosa Militar, Supervisor of Health Education, Bureau of Education, Manila.

Section of Public Health Nursing, Filipino Nurses' Association—Chairman, Maria L. Tinawin, American Red Cross, Philippines Chapter, Red Cross Bldg., Manila.

Bureau of Health—Section of Nursing, Genara S. Manongdo, Chief, Manila.

Philippine Islands Anti-Tuberculosis Society—Dr. Emilia Lantin, Chief Nurse, Anti-Tuberculosis Building, Manila.

Bureau of Education—Rosa Militar, Supervisor Health Education, Manila.

Social Service Unit, City of Manila—Mrs. Socorro Salamanca Diaz, Superintendent, Bureau of Public Welfare, Manila.

American Red Cross Philippines Chapter—Maria L. Tinawin, Director Nursing Service, Manila.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, BOSTON, MASS.

Nursing Supervisors

Director, Sophie C. Nelson.
Assistant Director, Agnes V. Murphy.
Assistant to the Director, Ethel V. Inglis.
Assistant to the Director, Katharine E. Peirce.

METROPOLITAN LIFE INSURANCE COMPANY, NEW YORK, N. Y.

Nursing Supervisors

Mrs. Helen C. LaMalle, Supt. of Nursing, 1 Madison Ave., New York, N. Y.
Margaret E. Kearney, Asst. Supt. of Nursing, 1 Madison Avenue, New York, N. Y.
Maud E. Steeves, Asst. Supt. of Nursing, 1 Madison Avenue, New York, N. Y.
Alice Bagley, Asst. Supt. of Nursing, 600 Stockton St., San Francisco, Cal.
Alice Ahern, Asst. Supt. of Nursing, 180 Wellington St., Ottawa, Ontario, Canada.

Territorial Supervisors and Territory

(All to be addressed at 1 Madison Avenue, New York, N. Y.)

Carolyn M. Hidden: Greater New York, Long Island, Westchester County.
L. Carey Jones: North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana.
Isabelle Carruthers: Missouri, Kansas, Oklahoma, Arkansas, Tennessee.
Mary Harrigan: Michigan, Wisconsin, Minnesota, Iowa, Nebraska.
Ruth H. King: Pennsylvania.
Monica Moore: New Jersey, Delaware, Maryland, District of Columbia, Virginia.
Sara O'Meara: New York State (except Westchester County).
Ellen Atchison: Massachusetts, Connecticut, Rhode Island, Maine, New Hampshire, Vermont.
Eva D. Calhoun: West Virginia, Kentucky, Ohio.
Irene McCullough: Illinois, Indiana.

Group Nursing Consultant

Ruth Waterbury, 1 Madison Ave., New York.

Group Nursing Supervisor

Mary J. Horn, Room 1200, 135 So. LaSalle St., Chicago, Illinois.